DOCUMENT RESUME

ED 431 980 CG 029 331

AUTHOR Martin, Graham; Clark, Shelia; Beckinsale, Paul; Stacey, Kathleen; Skene, Clive

TITLE Keep Yourself Alive. Prevention of Suicide in Young People: A Manual for Health Professionals.

INSTITUTION Southern Child and Adolescent Mental Health Service, Bedford Park (South Australia).

ISBN ISBN-0-646-32424-1

PUB DATE 1997-00-00

NOTE 113p.

AVAILABLE FROM Child and Adolescent Research Unit, Southern Child and Adolescent Mental Health Service, Flinders Medical Centre, Bedford Park, South Australia 5042, Australia; Tel: 08-8204-4212; Fax: 08-8204-5465.

PUB TYPE Guides - Non-Classroom (055)

EDRS PRICE MF01/PC05 Plus Postage.

DESCRIPTORS Audiovisual Instruction; *Counselor Role; Depression (Psychology); Educational Media; *Emotional Problems; Foreign Countries; Government School Relationship; Health Promotion; High School Students; High Schools; Males; Needs Assessment; *Prevention; Program Implementation; *Suicide; Theory Practice Relationship

IDENTIFIERS Australia (South Australia)

ABSTRACT

This manual is a ready reference guide to audio-visual resources of the "Keep Yourself Alive" program. It provides information for use with patients and clients as well as for personal professional development. Issues covered can be upsetting, and this material is not intended for direct use by children and young people. The "Keep Yourself Alive" program provides a comprehensive guide to educate general practitioners and health professionals as part of a national strategy aimed at reducing the youth suicide rate in Australia, which has the highest suicide rate in the world for people 15-24 years. Information is presented to help manage suicidal behaviors and completed suicide, and to improve crisis, therapy, and postintervention skills for workers in this challenging area. The manual includes a guide to the resource package, which describes its contents and how to use the materials, and the following chapters: (1) "The Problem of Suicide in Young People"; (2) Intervention with Suicidal Young People"; and (3) "After Suicide: Picking up the Pieces." Appendices include instructions for workshop providers and general practitioners, registration and evaluation forms, practice assessment option, and attendance certificate. (Contains a list of resources for bereavement.) (Author/JDM)

KEEP YOURSELF *ALIVE*

PREVENTION OF SUICIDE IN YOUNG PEOPLE

A MANUAL FOR HEALTH PROFESSIONALS

KEEP YOURSELF *ALIVE*

AUTHORS: DR GRAHAM MARTIN
DR SHEILA CLARK
DR PAUL BECKINSALE
MS KATHLEEN STACEY
MR CLIVE SKENE

PUBLISHED BY: FOUNDATION STUDIOS ADELAIDE, SOUTH AUSTRALIA
GRAPHIC DESIGN: LINDA SLAGHEKKE
PHOTOGRAPHY: RACHEL HARRIS AND BRETT SHERIDAN
PREPRESS BY: IMAGESET
PRINTED BY: ARTEGRAFICA

ISBN 0 646 32424 1

FUNDED UNDER THE AUSTRALIAN COMMONWEALTH GOVERNEMENT'S 'HERE FOR LIFE' YOUTH SUICIDE PREVENTION INITIATIVE

PREVENTION OF SUICIDE IN YOUNG PEOPLE
A MANUAL FOR HEALTH PROFESSIONALS

CONTENTS

INTRODUCING THE PROJECT ..... i-ii
ACKNOWLEDGEMENTS iii
A GUIDE TO THE RESOURCE PACKAGE
- Its Purpose iv
- The Contents iv
  - The Videocassettes v
  - The Audiocassettes v
  - The Workshop Diskettes vi
  - The Poster vi
  - The Manual vi
  - The Flier vi
- Using the Materials vii
  - The Videocassettes vii
  - The Audiocassettes vii
  - The Workshop Diskettes viii
  - The Poster viii
  - The Manual viii

CHAPTER 1
THE PROBLEM OF SUICIDE IN YOUNG PEOPLE
- The Background 1
- What to Look For 2
- Key Indicators 2-3
- Depression 3-4
- Hopelessness 5
- Anxiety 5
- Impulsivity 5
- Attributional Style 6
- The Spectrum of Suicide 6
- Physical and Sexual Abuse 7
- Alcohol and Drug Abuse 8
- Knowledge of Suicide 8
- A History of Loss 8
- Music Preference 9
- Demographic Factors 9
- Family Closeness 9
- Parental Style 10
- Academic Attainment 10
- Dealing with Indicators 10
- Counselling 11-12
- References 13-15

CHAPTER 2
INTERVENTION WITH SUICIDAL YOUNG PEOPLE .....
- Crisis Intervention 17
  - Definition 17
- Stages of Crisis 18
- Crisis Intervention Steps 19
  - Patient/Client Assessment (5) 19-21
  - Mental State Examination 22-23
  - 6 Stage Model 24-25
- Preparing for a Possible Suicide 26
- Brief Family Therapy 27
  - The 1st Session* 28
  - The 2nd & Subsequent Sessions* 29
- Beginning Therapy 30-32
- Cognitive Behaviour Therapy 33
- Didatic Approaches 34
- Cognitive Approaches 34-40
  - Faulty Think/Cog Distortions† ... 36
- Narrative Therapy: An Overview ... 41-46
  - References & Resources 47-48

CHAPTER 3
AFTER SUICIDE: PICKING UP THE PIECES 49
- Overview 49
- Why is This an Issue? 50
- Postvention in the Community 51-53
- Language: Bereavement & Postvention . 53
- The GP's Response to a Suicide ... 54-55
- Immediate Assistance for the Family .. 56
- Viewing the Body 57
- What to Tell Others 58
- What to Tell the Children 59
- Advising About the Funeral 60
- Support 60-61
- Initiate Good Grieving Habits 61
- Medication 62
- The Suicide Note 63
- The Coroner's Office 64
- The Role of the Funeral Director 65
- The Funeral 65
- Grief Reactions After Suicide 66-68
  - The Grief Map* 67
- Helping the Family with Guilt 69
- Discuss the Models of Suicide 69-70
- Variants of Grief 70
- Children, Young People and Grief:
  - Assisting the Parents 71-72
  - Follow-up of the Bereaved ... 72-73
- Grief Counselling 73-74
- References 75
- Resources for Professionals 76
- Books 77
- Videos 77
- Suicide Bereavement Support 78-79
- Appendices 80-98

APPENDICES

1A Instructions for Workshop Providers to General Practitioners 80-81

1B Instructions for Workshop Providers for Other Health Professionals 82

1C Instructions for General Practitioners Undertaking "Keep Yourself Alive" as a Distance Learning Program ... 83-84

1D Practice Assessment Option - "Young People in Your Practice" 85

2.1 Provider Registration Form 86

2.2 Sample of GP Attendance Certificate .. 87

2.3 GP Registration Form 89-90

2.4 GP Evaluation Form 91-92

2.5 Case Scenario Example 93-94

2.6 Other Health Professional Registration Form 95

2.7 Other Health Professional Evaluation Form 97-98

DIAGRAMS*

1 Brief Family Therapy The First Session 28

2 Brief Family Therapy The Second & Subsequent Sessions... 29

3 The Grief Map 67

TABLES†

1 Faulty Thinking or Cognitive Distortions 36

Project Executive:

Dr Graham Martin,
Executive Director, Southern Child and Adolescent Mental Health Service,
Senior Lecturer, Dept of Psychiatry, Flinders University of South Australia

Dr Sheila Clark, General Practitioner,
Senior Lecturer, Dept of General Practice, University of Adelaide.

Dr Paul Beckinsale, General Practitioner,
Education & Development Officer,
Royal Australian College of General Practitioners (SA Faculty)

Project Reference Group

Dr Michael Fasher, New South Wales
Dr Karen Flegg, New South Wales
Dr Virginia McAndrew, Northern Territory
Dr Barry McGrath, Queensland
Ms Jonine Penrose-Wall, New South Wales
Ms Sue Sutherland, South Australia
Dr Kingsley Whittenbury, Queensland
Dr Ian Wilson, South Australia
Mr Stephen Wright, Australian Capital Territory

Senior Project Officer

Ms Jeanne Lorraine

Video Resources:

Written and Co-produced by Marsha Dearden of
Marsha Dearden Communications, Tel 08-8232-0933

Produced and Directed by Andrea Hickey, TVWorks, Mob 041-1408-682

Audio Resources:

Produced by Tony Ryan, University Radio 5UV, Tel 08 8303 5000

Contact Details for Project:

KEEP YOURSELF ALIVE Project
Southern CAMHS
Flinders Medical Centre
BEDFORD PARK SA 5042

Telephone: 61 + 8 8204 4212
Facsimile: 61 + 8 8204 5465
Email: jeanne.lorraine@flinders.edu.au

and

Royal Australian College of General Practitioners

Quality Assurance and Continuing Education Unit (SA)
15 Gover Street
NORTH ADELAIDE SA 5006

Telephone: 61 + 8 8267 1888
Facsimile: 61 + 8 8361 8667
Email: gmalkin@racgp.org.au

Department of General Practice

University of Adelaide
North Terrace
ADELAIDE SA 5005

Telephone: 61 + 8 8303 3463
Facsimile: 61 + 8 8303 3511
Email: seclark@medicine.adelaide.edu.au

ACKNOWLEDGEMENTS

The original **YOUTH SUICIDE:** Recognising the Signs video resource package was developed with grants from the South Australian Health Commission Primary Health Care Initiatives Program, the Child Health Foundation and Morialta Trust Incorporated. Dissemination was supported by Southern Child and Adolescent Mental Health Services, The Royal Australian College of General Practitioners (Quality Assurance & Continuing Education Unit, S.A.), the Australian Medical Association (S.A. Branch) and Smithkline Beecham Pharmaceuticals.

In response to requests **YOUTH SUICIDE:** Recognising the Signs was redeveloped for high school teachers, counsellors and guidance officers. One copy has been made available to every high school and R-12 school in South Australia with financial assistance from Springfield Help for Small Charities. Further copies of both versions may be purchased from Southern CAMHS.

KEEP YOURSELF ALIVE is a comprehensive program to educate general practitioners and health professionals as part of a national strategy aimed at reducing youth suicide rates in Australia. KEEP YOURSELF ALIVE is funded under the Commonwealth Here for Life Youth Suicide Prevention Initiative.

The poster was funded by the South Australian Health Commission.

The **KEEP YOURSELF ALIVE** team would like to acknowledge the following professionals and organisations who contributed to the development of the program:

Dr Graham Fleming, Dr Victoria Wade, Dr Chris Holmwood, Dr Veda Rengasamy, Dr Chris Wurm, Dr Jill Benson, Dr Glyn Brokensha, Dr Don Clarkson, Dr Catherine Howell, Dr Tanya Kaouna, Dr Michael Lee, Dr Trevor Maxwell, Dr Jennifer Goold, Dr Farooq Qureshi, Dr Jonathan Martin, Dr Chris Wurm, Jennifer Newton, Sean Rafferty, Baldwin Van der Linden, Sue Sutherland, Adam Sutherland, Shane Hughes, Graeme Blakey, Anton Bryker, Aaron Hogben, Mr Chris Stone, Kenton Miller, David Akbar, Professor Ernest Hunter, Kate Treharne, Jenny Davis, Harold Jones, Michael Bull, The Highbury Family Practice, Dept of General Practice, University of Adelaide, Royal Australian College of General Practice, Southern CAMHS in particular, Kathleen Stacey, Clive Skene, Andrew Wood, Penny Munro, Helen Sara, Robyn Duckworth, Jill Knappstein, Lois Cochrane and Jody White.

KEEP YOURSELF ALIVE

Prevention of Suicide in Young People:
A Resource Package for Health Professionals

ITS PURPOSE

Goal 1.

To provide a comprehensive introductory guide to the management of suicidal behaviours and completed suicide.

Goal 2.

To raise the awareness of professionals with regard to the seriousness of suicidal behaviours in Australia, and to improve crisis, therapy and postvention skills for working in this challenging area.

CONTENTS

This educational resource package for general practitioners and community health professionals includes:

- four videotapes,
- two audiotapes,
- this manual,
- a poster, and
- a workshop guide on diskette (PC and Macintosh format).

The Resource package may be purchased as a whole, or each of the components may be purchased separately.

A GUIDE TO THE RESOURCE PACKAGE

THE VIDEOCASSETTES

1. YOUTH SUICIDE: Recognising the Signs
2. YOUTH SUICIDE: What Do I Do Now? Crisis Intervention
3. YOUTH SUICIDE: What Do I Do Next? An Introduction To Therapy
4. AFTER SUICIDE: Picking Up The Pieces

THE AUDIOCASSETTES

Module 1:
Recognising the Signs

1. The Reality of Youth Suicide
2. Young People at Risk
3. Young People at Risk
4. Issues of Confidentiality and Privacy
5. Issues for Gay and Lesbian Young People
6. Issues for Aboriginal Young People

Module 2:
The Role of the General Practitioner and other Health Professionals

7. Therapies - Introduction
8. Therapies - Action Method Therapy and Logotherapy
9. Therapies - Narrative Family Therapy
10. Therapies - Brief Therapy Techniques, Solution Focused Therapy
11. Discussion and Review Session

Module 3:
After a Completed Suicide

12. The General Practitioner's Reaction to a Young Person's Suicide
13. Immediate Support Following a Suicide
14. Ongoing Support for the Bereaved
15. Intervention with the School Community
16. Looking to the Future

A GUIDE TO THE RESOURCE PACKAGE

THE WORKSHOP DISKETTES

The diskettes in PC and Macintosh format contain workshop guides with appropriate handouts and overheads.

THE POSTER

A colourful poster, aimed at young people has the message to **"KEEP YOURSELF ALIVE"** with information about where to reach out for help and space for local service contact information.

THE MANUAL

Martin G, Clark S, Beckinsale P, Skene C, Stacey K, 1997

KEEP YOURSELF ALIVE: Prevention of Suicide in Young People: A Manual for Health Professionals, Foundation Studios, Adelaide.

This manual accompanies **KEEP YOURSELF ALIVE:** Prevention of Suicide in Young People: A Resource Package for Health Professionals. While this manual is copyright (*KEEP YOURSELF ALIVE* Project, Commonwealth Dept of Health and Family Services © 1997), permission is granted for copies to be made of materials on diskettes for personal study and/or multiple copies to be made for workshop participants.

THE FLIER

This gives information about the complete resource package and the book *After Suicide: Help for the Bereaved* Clark, S., which is the recommended resource for the bereaved.

USING THE MATERIALS

The Videocassettes

The videocassettes are intended as a guide for professionals; they may be watched alone, or as part of a seminar or workshop. The videocassettes are not primarily intended to inform members of the general public but we recognise that they may be used as part of an open and/or non-professional forum. Any audience (professional or lay) needs some preparation, as the issues discussed can be upsetting, particularly to those who have had some experience with loss through suicide or may themselves have been involved in suicidal behaviours. We would recommend that people are forewarned at the outset, and that professional support is available immediately at the end of a workshop if required. It is the responsibility of the convenor or presenter to:

- be aware of the responses which may occur
- be sensitive to members of an audience who become emotionally distressed
- allow open discussion of the issues raised
- arrange for suitable immediate and ongoing support, if necessary

The Audiocassettes

The audiocassettes were designed to promote discussion on a number of issues related to suicidal behaviours in young people. In particular, the audiocassettes record personal experience and opinion which augment the videotapes and the workshop program. Each of the 16 segments runs for about 12 minutes.

The Workshop Diskettes

We have designed a 7 hour experiential, education component to be delivered in a locally relevant, one or two day workshop format. The materials on the accompanying diskettes may be freely printed off and used as resources for the workshops. The overheads are designed as visual aids; they are referenced in the workshop guide and contain accurate information at the time of going to press.

The Poster

The poster is designed to be placed in waiting rooms and other areas where young people congregate. It has space for local contact information and may be used to direct young people to services that are accessible and can provide help.

The Manual

The manual is a ready reference to the audio-visual resources. It provides information for use with your patients/clients as well as for your own professional development.

WARNING:
The materials in the
KEEP YOURSELF ALIVE
Resource Package
with the exception of the poster and grief map
ARE *NOT* INTENDED FOR DIRECT USE
WITH CHILDREN OR YOUNG PEOPLE.

THE BACKGROUND

For young people aged 15-24 years, Australia has the dubious honour of having one of the highest rate of suicide in the world at about 16 per 100,000,[1] and suicide exceeds accidents as the premier cause of deaths in males for this age group. What this means is that more than 400 young people in Australia die each year by their own hand. Suicide is rare in the 10-14 year age group (rate 0.6 per 100,000), but there may still be between 5 and 10 child deaths nationally from this cause. Despite these figures, death from suicide is a rare event which is difficult to predict.[2]

Risk factors for completed suicide[3] overlap with those for attempted suicide, which is conservatively estimated to be at least 50 times more frequent.[4] At least 20,000 young people may attempt suicide each year in Australia, placing an immense burden on their families as well as professional and hospital services. A previous attempt is a risk factor for both a further attempt[5] and, ultimately, death from suicide.[6] If we accept that attempted suicide is in a continuum from thoughts to completion[7] it makes sense to provide early intervention to suicide attempters. Comprehensive assessment, therapy, and thorough follow-up should now be routine after discovery of even a non-lethal attempt in the community, or following admission to hospital with a serious attempt. However, school and community surveys,[8/9] demonstrate that 10-15% of young people claim to have attempted at some stage in the previous year; over 60% of these do not actively seek medical or other professional attention. Most of these young people are therefore lost to follow-up or intervention unless professionals take every opportunity to elicit the right information and provide appropriate support.

One solution to this problem is to increase the likelihood of gaining access to those suicidal young people not admitted to hospital. General Practitioners and Community Health Professionals are a key resource in the community, in every day contact with young people, and therefore in an ideal position to recognise emotional problems in young people, detect cases early where a young person has suicidal ideas or a past history of worrying behaviours and intervene at a primary care level.[10]

It is known that 60% to 80% of suicide attempters attend a health professional in the months prior to an attempt. Young people are often reticent to seek advice on emotional matters and may disguise their problems behind a minor physical problem. Evidence from a British study of general practice, for instance, suggests that young people attending on four or more occasions in one year have a 29% likelihood of an underlying emotional illness.[11] There is international evidence that where health workers and other professionals have been educated in suicide prevention, intervention and postvention, the rate of attempted and completed suicide has been reduced.[12]

WHAT TO LOOK FOR

Adolescents are often quite transparent, but you have to be looking to be able to see through them. While they may present initially with what appears to be an innocuous or minor physical or relationship problem, they often give themselves away by their manner, hints in their conversation or dress. Any young person presenting frequently in any one year should be asked about their emotional status. It is worth noting that young people (particularly young men) who act out, are repeatedly rude or provocative or get themselves into trouble in minor ways may have an underlying emotional problem. Conduct disorder, drug and alcohol abuse, graffiti, fights and even fire setting may be attempts to deal with overwhelming angry feelings.

Don't be fooled and just dismiss them as a trouble-maker; always check out the background circumstances, recent relationship problems and the level of anxiety or depression. In fact, it is worthwhile to ask a few key questions about emotional functioning whenever the opportunity arises.

KEY INDICATORS

Risk factors for suicidal behaviours can sometimes be cultural; can come from underlying influences related to community expectations of young people, may develop out of family dysfunction or poor parenting. They may result from educational or work failure leading to poor self esteem, a feeling of loss of control over personal decisions, and pessimism about the future.

A recent loss of any kind, a failure to gain attention or help, or a rejection may lead to a belief that life is not worth living or cannot be changed, or that relatives and friends will be punished if the young person dies and they believe it to be their fault. Impulsive attempts *may* result from a wish to die, but more commonly are seen as a way to relieve inner psychological pain, or a way to get away from some intolerable circumstance. No single factor will create suicidal behaviours. Most commonly there is a build up of risk factors and other stressors over time toward some flashpoint.

What we hope from this resource package is that professionals working with young people will see, understand and want to intervene in the build up before the flashpoint is reached. A number of major risk factors (key indicators of increasing risk for suicidal behaviours) are described below. Remember that no single factor will cause suicide, but recognition of one may lead to the search for others to get the whole picture.

DEPRESSION

In psychological autopsies, that is where the full story of the young person, their family and the circumstances leading up to the death are searched for clues, depression is the most common finding.[5] In large scale studies it is the most common associated factor.[13/16] It is clear that depression in young people may exist separately from suicidal behaviours and vice versa,[17/18] but there is considerable overlap and it appears to be the best single predictor of recurrence of suicidal thoughts and acts.[19] Arguments abound as to how depression should be defined. The clinical judgment of psychiatric professionals is based on positive responses to a list of key questions about feelings, thoughts and bodily functions, added to the emotional tone (or 'affect') perceived in the patient, as well as how the physician responds empathically to the patient. Questionnaires and scales can be used as adjuncts; however these are time consuming and while they appear to offer facts as figures and may back up clinical judgment, they may not add as much as we would like to believe to a careful piece of history taking.

In our experience, young people are surprisingly good at estimating their own degree of depression. As demonstrated on the video we recommend asking a 'scaling question': *"With 0 as no depression and 10 as the most severe depression you can imagine, how depressed are you?"*

Depending on the presence or absence of other factors, a score of up to and including 3 suggests the emotional state may be managed with supportive counselling of the young person and their family. A score of 4 to 6 inclusive may require referral for psychological or medical assessment, and treatment which may include specialist forms of psychotherapy and/or the use of an antidepressant, particularly if vegetative features (that is physical effects) of depression, or minor self destructive behaviours, are present. A score of 7 or over must be followed by exploration of the spectrum of suicide behaviours as well as careful evaluation of the depression and other factors. If you are skilled, trained and comfortable with the problems and the young person, consider doing the treatment, individual counselling and family or school intervention yourself. If you are not trained or comfortable, it may be wise to refer for medical or specialist assessment and help.

Remember, this is a time consuming and demanding area.

- You must have the time to do a good job.
- You must like working in this way.
- Never work alone.
  Always check with a colleague, even if you work in rural or remote areas. The Doctors' Health Advisory Services is a confidential resource for medical practitioners.
  (see Bereavement Section).
- Don't be fooled.
  Remember that young people may or may not present the classical picture of depression; often they present as angry, resentful and acting out as a way of dealing with the inner feelings.
- In rare cases this may be the first episode of a clinical depressive illness. If the depth of the depression is serious, or if the physical effects are marked, or if it continues despite your best help, always make a referral.

HOPELESSNESS

Hopelessness has been shown to be an important construct related to suicidal intent and eventual completed suicide. Beck has gone so far as to suggest that it may be a better predictor of ultimate death from suicide after a suicide attempt than depression.[20] We consider that it is often part of more serious depressions, though it can be argued that young people are entitled to have a level of pessimism or hopelessness about their future given the current economic recession, the daily barrage of news events detailing the ills of the world, and the high likelihood of permanent unemployment in the future - particularly for those with limited education and skills.

ANXIETY, OBSESSIONAL BEHAVIOURS AND PHOBIC DISORDERS

The literature suggests that these disorders are not only more common than we have thought in the past, but are associated with suicidal behaviours as much as depression.[21] This may be surprising, but anxiety is certainly crippling for young people and can make social relationship formation very difficult at a time of their lives when this is paramount. A chronic sense of inferiority and incompetence may result. Always run through a checklist of common anxieties with young people if there appears to be some emotional problem. Use scaling questions to gauge how severe the anxiety is.

IMPULSIVITY

Deaths from suicide may be divided into two groups - those resulting from an attempt carefully planned over time, and those resulting from impulsive (or spur of the moment) acts.

Those that are carefully planned are difficult to predict and we know that it is difficult to stop all young people who decide to suicide from doing so. However, the combination of a history of impulsivity in the past, a need to get back at someone in the family or circle of friends, or the need to get someone special to take notice is a risk factor for a further attempt. The solution may be to explore and rectify the social situation without reinforcing that the threat of suicide is a good way to get your own way.

ATTRIBUTIONAL STYLE

Studies in young adults have shown that a high belief in external control and chance is associated with suicide attempts.[22] Conversely a sense of being in charge of your own life, understanding how to make informed judgments about events, and having thought about your options in various life situations can protect young people. Our own work supports these conclusions.[8] The issue here is that young people often need to be helped to gain a sense of control over themselves and their world through clear problem definition, good decision making and small successful steps toward a solution for their unique difficulties.

THE SPECTRUM OF SUICIDE

Many previous studies on suicide have been based on responses to single questions on thoughts or acts,[9/25] complex additions based on responses to these two questions,[23] or short scales. Mostly data produced has been categorical and criticism has been levelled at the statistical results. Further, argument continues over the interrelationship between aspects of the spectrum of suicide. To solve these problems, the team at Southern CAMHS (Child and Adolescent Mental Health Service) at Flinders Medical Centre in South Australia has developed the Adolescent Suicide Questionnaire (ASQ – R)[4] which incorporates all aspects of the suicide spectrum. We have maintained questions which provide categorical data, but in addition have tried to increase the flexibility to give more options. In addition we have developed questions which will provide interval data. Results should therefore be stronger and conclusions drawn from statistical inference more valid. In its simplest form, you simply seek the presence of:

- Suicidal Thinking (score 1)
- Suicidal Threats made to others (score 2)
- Suicidal Planning (score 3)
- Deliberate Self Harm of any seriousness (score 4)
- A Previous Attempt at Suicide (score 5)

What we have shown[4] is that if you apply the score shown in parenthesis, and then add the total score, any score 6 and over should provoke your concern and lead to careful further assessment, treatment and support planning. If the young person claims to have attempted suicide, you should ask if they really wanted to die (score extra 1 if they did), if what they took or did could have actually completed the suicide (score extra 1 if they believed their actions were lethal), and if they were glad they did not succeed (score extra 1 if 'no'). These three questions may appropriately raise your concerns further.

There has been concern about the asking of such questions of young people. Shaffer[25] has rightly drawn attention to the possibility of influence from preventive programs in schools which include discussions with young people about such ideas. Further, there is clear evidence of a contagion effect in young people in as much as an increase in attempts and deaths is seen to occur following newspaper and media reports of suicide. *However, there is no suggestion or evidence in the literature that supports such an effect resulting from asking such questions in the clinical context where there is a clear contract for help.* It appears that only those who have already considered suicide as an alternative are easily influenced, and then not by questions and/or discussion, but only by another's death from suicide, and then more strongly when they have been involved in the event or seen the body.[26/27]

It is our belief and experience that asking clear, straightforward questions of young people leads to clear, direct, honest answers, and is the only way to predict later vulnerability.

PHYSICAL AND SEXUAL ABUSE

Clinically, both of these appear frequently in the histories of those who attempt suicide. In the few studies which have been done there is evidence of an association between abuse and suicide. Our own work suggests that 47% of those who claim to have attempted suicide also claim a history of abuse.[28] Just remember that in exploring these issues you may have to report the result to the Police or the Family and Community Services in your state if you have reasonable grounds for suspicion that the young person has been abused.

ALCOHOL AND DRUG ABUSE

There is evidence in the literature of a strong association between both alcohol and drug intake (frequency and quantity and abuse).[29] We recommend that you explore this issue fully if there is a suspicion of substance abuse. Remember that young people often turn to drugs to try to lift their mood or help their problems, without realising that drugs and alcohol are likely to exaggerate a feeling state.

KNOWLEDGE OF SUICIDE

There is evidence in the world literature that those who have experienced death from suicide in either family members, friends or close associates, are more at risk for suicidal thoughts and behaviours.[26/27] This has an implication for closed environments like schools, colleges or universities where young people find out about deaths from suicide very quickly. If this occurs in an establishment where you work, then a good piece of preventive medicine is to be aware that you may get an upsurge in both friends and relatives struggling to come to terms with the death. Some young people will be vulnerable to influence and a quick conversation with a teacher, lecturer, counsellor or chaplain is likely to identify these young people easily.

EARLY INTERVENTION WILL SAVE LIVES.

A HISTORY OF LOSS

There is also evidence in the world literature that those who have experienced death in the family are more at risk for suicidal thoughts and behaviours.[30/31] Don't just assume that a young person will eventually get over it. They need assistance, support and a network of friends.

MUSIC PREFERENCE

A curious outcome in some of our research has suggested an association between preference for rock/heavy metal music and suicidal behaviours.[32] This cannot be taken in isolation, but may be one indicator to help you identify a young person in real trouble. Listening obsessively to songs about death and dying or suicide, having a particular interest in pop stars who have committed suicide are key issues. This is particularly true for young women who as a group are less likely to prefer heavy metal unless it is serving a particular purpose in their lives. Take especial note of those young people who feel worse after listening to their favourite music (or perhaps worse after any experience supposed to make them feel better).

DEMOGRAPHIC FACTORS

There is evidence in the literature that while youth suicides do occur throughout all social classes, there is a predominance of attempted suicide in lower socio-economic classes. This may be related to family structure, functioning, interpersonal skills particularly in the area of problem resolution, educational level, level of employment, quality of life, future prospects. It is too dangerous just to write someone off because you think they or their family are hopeless anyway.

FAMILY CLOSENESS

'Closeness' is a complex construct and may include the physical relationship of being close and touching, the emotional feeling tone associated with relationship, and the concepts of caring and concern. It may also perhaps have negative connotations relating to being bound by family ties. However, in other work[33] closeness appears to have a positive association with 'healthy' responses on the Family Assessment Device[34] and a positive association with high 'care' and low 'overprotection' on the Parental Bonding Instrument.[35] There appears to be a little association with two parent family structure as opposed to single parent structure;[33] in other words it is part of the family dynamic or process rather than structure. Exploring the closeness of relationships is an easy way to identify the adequacy of family or parental supports.

PARENTAL STYLE

Studies at Southern CAMHS suggest there are strong associations between parenting style (as measured on the Parental Bonding Instrument) and suicidal behaviours.[33] It appears that there are three key issues:

- Care
- Overprotection
- Criticism

The most lethal mixture is when the young person perceives that their parents do not care, are highly intrusive and controlling and highly critical without appreciation of the complexity of the young person's life or their successes.

ACADEMIC ATTAINMENT AND/OR WORK RECORD

There is clear evidence of academic and/or work failure being associated with suicidal behaviours.[36/37] Watch out for the sense of despair felt by those struggling with higher school certificates/university entrance, or tertiary studies, and in particular, sudden changes in performance. Loss of employment or persistent failure to obtain work is also a risk factor.

DEALING WITH INDICATORS

As we have already noted, any one of these factors in isolation is not likely to provoke suicidal behaviours. As with other diagnostic endeavours, what we do is to add together the risk factors and match them against supports and coping skills. The most lethal combination is severe depression in a hostile family environment, without other community supports, where there has been a recent death or attempt by a friend or relative and a serious loss, perceived loss or loss of face.

Don't be fooled by the young person's attitude to you or some other authority. See their manner, dress or behaviour as the way they have chosen to try to work through things for themselves. Always seek to discover depression or other emotional symptoms, even in the most apparently delinquent of young people.

COUNSELLING

Establishing rapport with the young person, understanding the problems and supporting through counselling are the subject of additional materials in this Resource package, in particular related sections of this manual as well as the audiotapes and the videos:

- YOUTH SUICIDE: What Do I Do Now? Crisis Intervention.
- YOUTH SUICIDE: What Do I Do Next? An Introduction To Therapy.

At this time it is important to state the following:

- Outcome for troubled young people seems related to therapeutic alliance, listening and understanding. Alliance is composed of the bond you create (in part the empathy you have with the young person's problems and circumstances) and the contract for solution or change.
- Be clear, open and direct;
- Never say you will do something which you can't;
- Always try to see the problem in the context of the family;
- Always get as much in the way of community support going as you can;
- Develop a clear contract with specific goals;
- Seek advice early rather than late.

A Focus on *Solutions rather than Problems* seems to be best:

- When was the problem not there?
- What were they doing at the time?
- What is the solution they seek?
- Precisely how will they know they have achieved it?
- How would others know that the change had occurred?

In addition, a focus on *Strengths rather than Deficits*, and *Successes rather than Failures* (even if these are minute initially) often leads to success:

- What have they succeeded at?
- How have they survived hard times?
- How did they develop the courage to .....?

Young people deserve a future; it is your role to observe when things might be going wrong and try to help turn things round. Don't expect any thanks; even when you are told you are interfering you may be doing something important for the long term that is hard for the young person to see in the present.

REFERENCES

1. **Harrison J, Cripps R,** 1994. *Injury Mortality Australia, 1992.* Australian Injury Prevention Bulletin, 6:2-3.

2. **Goldney R, Spence N,** 1987. *Editorial comment: Is suicide predictable ?* Australian and NZ Journal of Psychiatry, 21:3-4.

3. **Brent D, Perper J, Goldstein C, Kolko D, Allan M, Allman C, Zelenak J,** 1988. *Risk factors for adolescent suicide.* Archives of General Psychiatry, 45:581-588.

4. **Pearce C, Martin G,** 1994. *Predicting suicide attempts among adolescents.* Acta Psychiatrica Scandinavica, 90: 324-328.

5. **Pfeffer C, Klerman G, Hurt S, Lesser M, Peski, J, Siefker M,** 1991. *Suicidal children grow up: demographic and clinical risk factors for adolescent suicide attempts,* Journal American Academy of Child and Adolescent Psychiatry, 30:609-616.

6. **Maris R,** 1992. *The relationship of non-fatal attempts to completed suicides.* In Assessment and prediction of suicide Maris RW, Berman AL, Maltsberger JT, Yufit RI (eds.), New York, Guildford Press.

7. **Pfeffer C, Zuckerman S, Plutchik R, Mizruchi M,** 1984. *Suicidal behaviour in normal school children: a comparison with child psychiatric inpatients.* Journal American Academy of Child and Adolescent Psychiatry, 23:416-423.

8. **Pearce C, Martin G,** 1993. *Locus of control as an indicator of risk for suicidal behaviour among adolescents.* Acta Psychiatrica Scandinavica, 88:409-414.

9. **Smith K, Crawford S,** 1986. *Suicidal behavior among "normal" high school students.* Suicide and Life Threatening Behavior, 16:313-325.

10. **Aldridge D,** 1992. *Suicidal Behaviour: a continuing cause for concern.* British Journal of General Practice, 42: 482-485.

11. **Bowman FM, Garrelda ME,** 1993. *Psychiatric morbidity among children who are frequent attenders in general practice.* British Journal of General Practice, 43: 6-9.

12. **Isometsa, ET, Heikkinen ME, Marttunen M, J Henriksson MM, Aro HM, Lonnqvist JK,** 1995. *The last appointment before suicide: is suicide intent communicated?* American Journal Psychiatry,152:6. 919-922.

13. **Lester J, Gatto J,** 1989. *Self-destructive tendencies and depression as predictors of suicidal ideation in teenagers.* Journal of Adolescence, 12: 221-223.

14. **Kienhorst CWM, De Wilde EJ, Van Den Bout J, Diekstra RFW, Wolters WHG,** 1990. *Characteristics of suicide attempters in a population-based sample of Dutch adolescents.* British Journal Psychiatry, 156: 243-248.

15. **Kosky R, Silburn S, Zubrick S,** 1986. *Symptomatic depression and suicidal ideation: a comparative study with 628 children.* Journal Nervous and Mental Disorder, 174: 523-528.

16. **Rubenstein JL, Heeren T, Housman D, Rubin C, Stechler G,** 1989. *Suicidal behavior in "normal" adolescents: risk and protective factors.* American Journal of Orthopsychiatry, 59: 59-71

17. **Carlson GA, Cantwell DP,** 1982. *Suicidal behavior and depression in children and adolescents.* Journal American Academy of Child and Adolescent Psychiatry, 21: 361-368.

18. **Kolvin I, Barrett ML, Bhate SR, Berney TP, Famuyiwa OO, Fundudis T, Tyrer S,** 1991. *The Newcastle Child Depression Project: diagnosis and classification of depression.* British Journal of Psychiatry, 159 (suppl. 11): 9-21.

19. **Garrison CZ, Addy CL, Jackson KL, Mckeown RE, Waller JL,** 1991. *A longitudinal study of suicidal ideation in young adolescents.* Journal American Academy of Child and Adolescent Psychiatry, 30: 597-603.

REFERENCES

20. **Beck AT, Steer RA, Kovacs M, Garrison B,** 1985. *Hopelessness and eventual suicide: a 10 year prospective study of patients hospitalized with suicidal ideation.* American Journal of Psychiatry, 142:559-563.

21. **Mattison RE,** 1988. *Suicide and Other Consequences of Childhood and Adolescent Anxiety Disorder.,* Journal of Clinical Psychiatry, 49: 10, 9-11.

22. **Topol P, Reznikoff M,** 1982. *Perceived peer and family relationships, hopelessness and locus of control as factors in adolescent suicide attempts.* Suicide and Life Threatening Behaviors, 12:141-150

23. **Rey JM, Bird KD,** 1991. *Sex differences in suicidal behaviour of referred adolescents.* British Journal Psychiatry, 158:776-781.

24. **Martin G,** 1992. *Adolescent Suicide 2: Postvention in a school.* Youth Studies Australia, 11, 1:24-27.

25. **Shaffer D, Garland A, Gould M, Fisher P, Trautman P,** 1988. *Preventing teenage suicide: a critical review.* Journal American Academy of Child and Adolescent Psychiatry, 27:6, 675-87.

26. **Martin G,** 1992. *Adolescent Suicide 3: imitation and the clustering phenomenon.* Youth Studies Australia, 11, 1:28-32.

27. **Brent DA, Perper J, Moritz J, Allman BS, Friend A, Schweers J, Roth C, Balach L, Harrington K,** 1992. *Psychiatric effects of exposure to suicide among the friends and acquaintances of adolescent suicide victims.* Journal American Academy of Child and Adolescent Psychiatry, 31:629-639.

28. **Martin G, Rozanes P, Pearce CM, Allison S,** 1995. *Adolescent suicide: disturbed family relationships as an indicator of vulnerability.* Acta Psychiatrica Scandinavica, 92:5, 336-44.

29. **Crumley FE,** 1989. *Substance abuse and adolescent suicidal behaviour.* JAMA, 263:3051-3056.

30. **Crook T, Raskin A,** 1975. *Association of childhood parental loss with attempted suicide and depression.* Journal Consult. Clin. Psychology, 43:277.

31. **Goldney RD,** 1981. *Parental loss and reported childhood stress in young women who attempt suicide.* Acta Psychiatrica Scandinavica, 64:34.59.

32. **Martin G, Clarke M, Pearce C,** 1993. *Adolescent Suicide: Music Preference as an Indicator of Vulnerability.* Journal American Academy of Child and Adolescent Psychiatry, 32:3, 530-535.

33. **Martin G, Waite S,** 1994. *Adolescent Suicide: Parental Bonding as an indicator of Vulnerability.* Acta Psychiatrica Scandinavica, 89:246-254.

34. **Epstein NB, Baldwin LM, Bishop DS,** 1983. *The McMaster Family Assessment Device.* Journal Marital and Family Therapy, 9:171-180.

35. **Parker G, Tupling H, Brown LB,** 1979. *A Parental Bonding Instrument.* British Journal Medical Psychology, 52: 1-10.

36. **Ritter DR,** 1990. *Adolescent Suicide: social competence and problem behaviour of youth at high risk and low risk for suicide.* School Psychology Review, 19:83-95.

37. **Spirito A, Overholser J, Hart K,** 1991. *Cognitive characteristics of adolescent suicide attempters.* Journal American Academy of Child and Adolescent Psychiatry, 30:604-608.

REFERENCES

OTHER RECENT RELATED PAPERS:

1. **Allison S, Pearce C, Martin G,** 1995. *Parental Influence, Pessimism and Adolescent Suicidality.* Archives of Suicide Research, 1:4, 229-242.

2. **Martin G,** 1996. *Depression in Teenagers.* Current Therapeutics, June, 7,6: 57-67.

3. **Martin G,** 1996. *The Influence of Television Suicide in a Normal Adolescent Population.* Archives of Suicide Research, 2:2, 103-117.

4. **Martin G,** 1996. *Reported family dynamics, sexual abuse and suicidal behaviors in community adolescents.* Archives of Suicide Research, 2:3, 183-195.

5. **Martin G, Goldney R,** 1997. *Editorial: Guns and Suicide.* Medical Journal of Australia, 166:1, 5.

6. **Martin G,** 1997. *Celebrity Suicide: Did the death of Kurt Cobain influence young suicide in Australia.* In Press. (Archives of Suicide Research).

7. **Martin G, Allison S, Pearce C, Cornelissen S, Rafferty S, Mead P, Williams K,** 1997. *Early detection of emotional disorder with particular reference to suicidal behaviours: a preliminary report.* 17th Geigy Symposium, Melbourne, Australia.

8. **Martin G,** 1997. *The Brief Adolescent Risk Taking Scale; preliminary validation studies.* Being assessed for publication (Archives of Suicide Research).

CRISIS INTERVENTION

DEFINITION OF CRISIS

There are many definitions of 'crisis' available but we have chosen to use the following description as a working model based upon the texts cited below.

'A crisis occurs when unusual stress temporarily renders an individual unable to direct life effectively. As the stress mounts and usual coping mechanisms provide neither relief nor remedy, the person often experiences extreme feelings of fear, anger, grief, hostility, helplessness, hopelessness and alienation from self, family and society.

The stress can be a reaction to a single event or to several events occurring simultaneously or serially'.[1]

A crisis can be a self limited event of indeterminate length and may last from a few days to several weeks. It is important to note that Crisis Intervention is not therapy. Rather it is the skilled attempt to stop emotional 'bleeding' in the same way that First Aid is applied to a physical wound. Successful intervention achieves problem management rather than problem resolution. Effective and timely Crisis Intervention can quickly re-establish equilibrium for the patient/client and usually reduces the need for ongoing intensive treatment.

STAGES OF CRISIS

- **Initial Reactions**
  The initial reaction may be similar to that of an acute anxiety state, with shock, fear, anger or grief predominating. The most common reactions among young people include severe and/or frequent somatic complaints, appetite and sleep disturbance, inability to concentrate, apathy, depression and loss of focus and irresponsible or delinquent behaviour. The most critical aspect is the loss of ability to cope with everyday activities such as work and family commitments where the normal coping mechanisms have previously been effective.

- **Subsequent Reactions**
  In normal circumstances, once the initial shock of a stressful event has been overcome, the individual usually moves to a state of problem solving. It is often during this process that a person's coping mechanisms are stretched to the limit. The degree to which they have been successful in resolving other issues in the past will often determine the successful resolution of the current crisis. Even if the individual has demonstrated adaptive coping skills with a previous crisis it does not mean that they will be able to cope with the current crisis. For example a person may have been able to deal with the grief surrounding the death of a parent but find themselves completely overwhelmed by a subsequent loss such as the suicidal death of their spouse or child.

- **Physical Symptoms**
  There are a number of physical symptoms which may indicate that an individual has been functionally immobilised by a perceived crisis. These include chest pain, headaches, loss of weight and appetite, fatigue indicating sleep disturbance, inability to concentrate, apathy and depression. Behavioural disturbance sometimes involving unusually excessive alcohol or drug intake and delinquent or anti-social behaviour may occur. Many of these symptoms are associated with high stress but the discriminating factors which indicate crisis are the inability of previously effective coping methods to resolve current issues and the resultant feeling of being trapped or immobilised.

- **Role of the Practitioner**
  The therapist should intervene where there is evidence that the coping skills of the individual are overwhelmed by the emotional pain of the current event. Active short term intervention during a crisis provides the opportunity to re-evaluate coping skills and expand the behavioural repertoire in order to deal more effectively with the next crisis. Clinical experience suggests that people in crisis are, in fact, more open to direction and change and more likely to adopt suggested strategies. In many ways crisis intervention can be seen as a preventative approach in that one of its aims is to provide better coping strategies and limit further psychological difficulties.

CRISIS INTERVENTION STEPS

PATIENT/CLIENT ASSESSMENT

Clients or patients rarely attend appointments with the awareness that their situation is one which is best described as a state of crisis. Rather they will present with one or several of the symptoms described above. In some cases discussion of an identified problem can precipitate a crisis reaction right then and there in your rooms.

Assessment is critical in Crisis Intervention.
It enables you to determine:

1. The severity of the crisis
2. The client's current emotional mobility
3. Available alternatives and resources
4. The level of perceived suicide threat and its lethality

In determining whether your patient or client should be considered in a state of crisis it is useful to use a 'triage' style of assessment of current functioning across the Affective, Cognitive and Behavioural domains.

The main areas to consider are:

1. **SEVERITY**

Severity may affect mobility and the degree of assessed mobility determines how directive the crisis worker should be.

- **Cognitive state:**
  How realistic and consistent is the young person's thinking?
  How open is the young person to changing beliefs about situations?
  How long have they been engaged in crisis thinking?

- **Affective State:**
  Abnormal affect is often the first sign of disequilibrium.
  (out-of-control or detached)
  You may need to help them express emotions in an appropriate realistic way in order to allow them to regain control.

Ask yourself :
- Is the emotional response congruent or atypical?
- Do responses indicate denial/avoidance?

- **Behaviour / Psychomotor Activity:**
  Crisis workers should encourage a focus on taking active steps.
  Crisis Survivors report the most helpful alternative offered to them in crisis was to engage in concrete and immediate activity.

Useful questions might be:
- What would have to happen for you to get back on top of the situation?
- Identify one or two people who would be supportive to you in this crisis.

2. EMOTIONAL STATE ASSESSMENT

Is the crisis acute or chronic?

Acute crises require direct intervention to re-establish equilibrium. Chronic crises require more time in counselling, finding supports, coping strategies etc.

How much emotional strength remains in the young person?

The greater the hopelessness/helplessness, the more direct the required intervention.

3. ASSESSING ALTERNATIVES

What choices are available **now** that will help restore the young person to a pre-crisis state of autonomy?

What institutional, social, vocational or personal strengths are available?

What are the impediments to progress?

Who would care for or assist the young person?

4. ASSESSING SUICIDE POTENTIAL

Not every crisis involves those who are contemplating suicide but ... the possibility must always be explored!

Most suicidal young people give definite clues and ***believe*** **that they are calling out for help.**

If they perceive their call as unheeded this may exacerbate their crisis.

5. SUMMARY OF ASSESSMENT

In a crisis situation there is no time to collect and analyse all available data and history. Successful crisis workers take what information is available and make meaningful sense of it, updating and upgrading their responses as they go. Assessment is a continuous, central process which should continue until pre-crisis equilibrium is re-established.

MENTAL STATE EXAMINATION

The following aspects need to be considered:

- **Appearance:**
  What is the state of dress and personal hygiene?
  What about their posture and body language - what messages do they convey?

- **Behaviour:**
  What does the patient do during the consultation?
  Are there any unusual mannerisms, gestures, odd behaviours?
  Is the patient motionless and seemingly paralysed by depression?

- **Conversation:**
  Is the patient able to maintain a coherent conversation?
  Is there any unusual timbre to the voice?
  Is there rapid or retarded speech?
  Are there any odd elements to the speech - repeated phrases, unusual use of words?

- **Affect:**
  Is the affect (that which the examiner observes as part of the consultation) normal, blunted, flat, constricted?
  A normal affect will allow response to the content of the conversation and show normal or expected emotional responses. A constricted affect is where the patient's emotional response is reduced in intensity to that which you would expect; blunted is even further depressed, and flat is where there is a profound reduction in emotional responses such that no appropriate emotion is shown.

- **Perceptions:**
  Is the patient experiencing any form of altered perception?
  Are they hallucinating?
  Are there any mannerisms that would indicate tactile hallucinations?

- **Cognition:**
  - **Memory:**
    Test short term and long term memory.
  - **Orientation:**
    Test that they are orientated in time, place and person.
  - **Associations:**
    Are the ideas expressed only tangentially connected?
  - **Thoughts:**
    What is the content of the thought expressed.
    Is there any paranoia?

- **Insight:**
  Does the young person recognise that there is a problem to be solved? A lack of recognition might be related to intellectual impairment, but also early signs of a serious mental disorder.

- **Rapport:**
  Can the young person make a relationship with you, and can you make a bond with them? Again, the loss of rapport may relate to a personality style or to early signs of mental disorder.

- **Judgement:**
  This may be impaired by medication, non-prescribed drugs or a serious mental disorder, as well as be limited by an intellectual capacity or education. Good judgement is crucial to the development of plans and decisions about resonable life options.

THE SIX STAGE MODEL OF CRISIS INTERVENTION

The following outline of the Six Stage Model is adapted from Gilliland and James (1993).[2] Space considerations only allow us to outline the model in brief. Further reading of the above text is highly recommended. This model is very useful once you have established that there is no obvious underlying psychiatric disorder and that all the signs and symptoms can be reasonably related to the event(s) precipitating the crisis.

Step 1: Define the Problem(s)

It is particularly important to do this from the perspective of the young person. This will require the use of both active and reflective listening skills to ensure that you are clear that the problems are the result of the crisis situation. With young people it is particularly important to be non-judgmental, allowing them to express their ideas in their own words. It is often helpful to use the same terminology used by the young person during the consultation process. Be sure to attend to both verbal and non-verbal messages.

Step 2: Ensure Safety

This may require some exploration with the young person. Make it clear to them that you are concerned about their safety and you want to be sure that they will be all right. Find ways that are acceptable to both of you to achieve this. Your fallback position (if there is no other avenue) may be hospitalisation - possibly under a detention order if you believe the young person's life is in danger. However, if you have to take this path make it clear to the young person that your paramount concern is their life and you are not going to take any chances with it!

Step 3: Provide Support

This can be done by identifying any caring adult with whom the young person will relate. You may also need to make some clear offers of support including ongoing consultations. Youth workers and other support services such as telephone counselling services should also be offered as options to the young person.

Step 4: Examine Alternatives

Find alternatives to the immediate problems precipitated by the crisis. If accommodation is a problem, find a way to identify possible emergency shelter. If there is a financial problem contact the local community welfare organisation or perhaps a voluntary organisation like the Salvation Army, Brotherhood of St. Lawrence or St. Vincent de Paul.

Step 5: Make Plans

Make clear plans with the young person to see them again and to have their immediate needs addressed. This may need to be documented for them, as the young person may not recall all the details of the conversation. Without a record, all they may have when they leave is an impression of your attitude towards them. If you are uncomfortable with the young person and feel that you may not be able to relate to their problems or personality ensure that your plans have identified a colleague or other health professional who can continue the counselling and support.

Step 6: Obtain Commitment

This is an essential element and needs to formalised. It is often best to do this in writing. Make notes on what you have agreed, provide them with a copy. To reinforce the agreement have someone who is involved with the young person act as a witness. If possible and relevant establish a "No suicide" contract until the next available meeting. This may need to be as soon as within the next few hours.

REFERENCES

1. **Greenstone JL, Leviton SC,** 1993. *Elements of Crisis Intervention.* Brooks Cole, Pacific Grove California.
An inexpensive but useful Handbook which can be kept handy as a ready reference text and quick revision aid. Covers a range of ages and situations.

2. **Gilliland BE, James RK,** 1993. *Basic Crisis Intervention Skills, in Crisis Intervention Strategies.* Brooks Cole, Pacific Grove California.
A detailed text for further in-depth study using case scenarios.

PREPARING FOR A POSSIBLE SUICIDE

Sixty percent of suicides are not unexpected. You may prevent the bereaved a lot of distress following a suicide if they have prepared for it. This is a similar process to that of helping families prepare for losing a loved one through a terminal illness. Even though the suicidal young person may not be receptive to the messages, the bereaved are comforted later that they had done everything possible.

1. Acknowledge with the family that the risk of suicide is high and despite everyone's efforts the young person may go on to take their life.
2. Ask the family whether they feel everything possible is being done and discuss any further strategies which might help.
3. Ask the family if they have said everything they would wish to say to the young person should that young person go on to take their life. Suggest they set aside a time to speak to them or write them a note. The important issues include:
   - the love they have for the young person;
   - how much that young person means to them;
   - how much they want to help the young person;
   - past disputes and differences are forgiven.

BRIEF FAMILY THERAPY

Brief Family Therapy is an approach developed at the Brief Family Therapy Centre in Milwaukee by Steve de Shazer and Insoo Kim Berg. It is related to a number of other brief therapy approaches and is based in a respectful expectation that most human beings are genuinely searching for solutions to their problems and capable of sustained change. De Shazer does not focus on problems either in an assessment phase or in early treatment; rather there is a search for when each problem described is not present or is at a reduced frequency or strength.

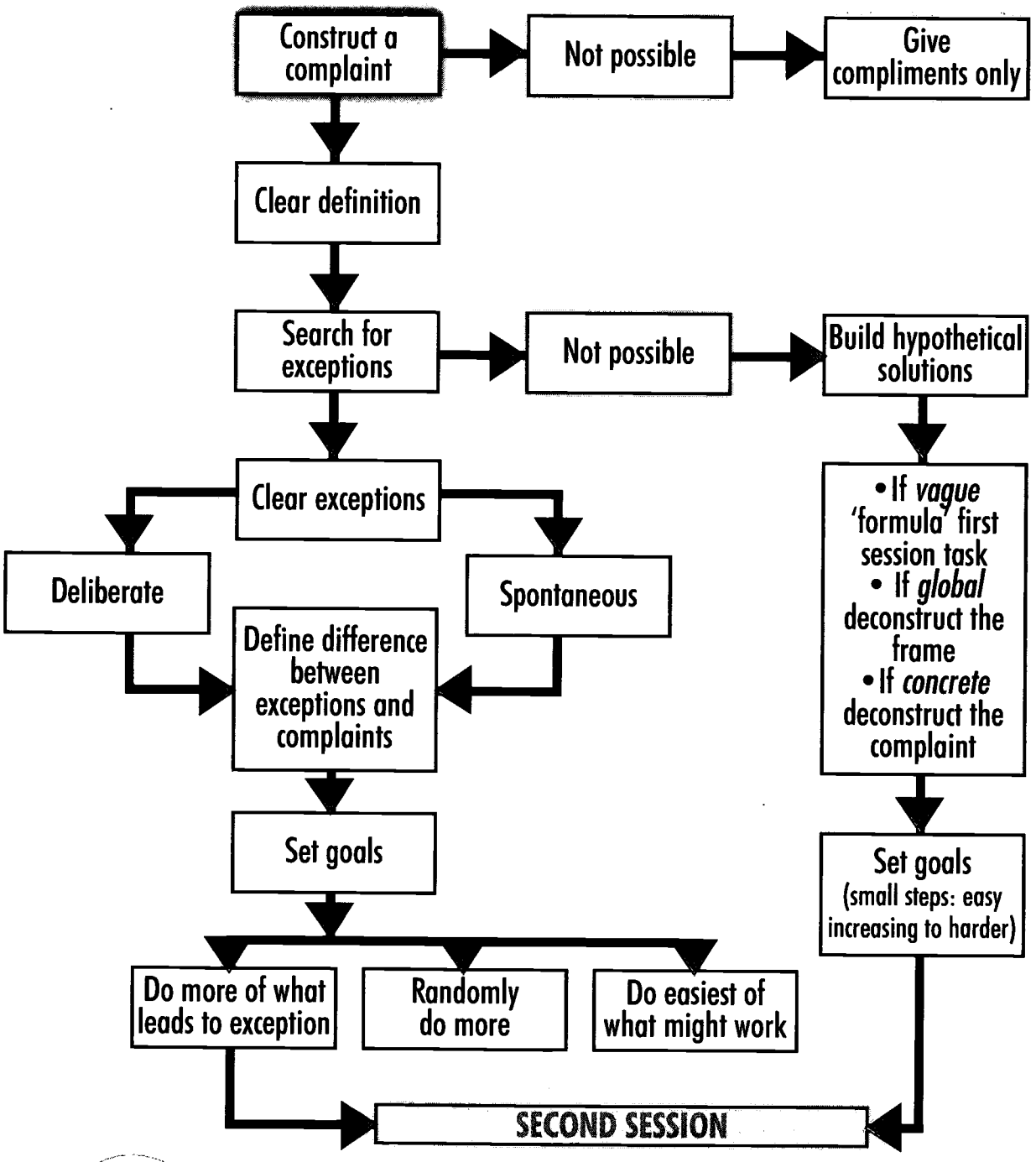
The therapy is very strongly systemic. That is the individual is seen as an integral part of their family system or living context, and there is an examination of who else is involved in the problem, how they contribute to the problem and how they might contribute to a solution.

De Shazer believes that commitment to the therapy is imperative to change. He uses the term "customer" to describe those who are clear about what they want to change or achieve. "Complainants" are described as those who do not own the problem and simply either wish to complain about their plight or complain about the others who appear to be responsible for the difficulty. This is a common situation with young people who are "brought" to therapy rather than necessarily seeking it for themselves. De Shazer suggests we need to turn the complaint into a problem which is owned. As an example the young person might agree that the complaints from parents are a problem for them which they could change. Or some alternative problem may be defined.

Finally de Shazer describes a group known as "visitors" who simply attend to "spy out the land." As an example the father in a family might believe that an errant son is not a problem with him or for him and if only his wife would stop nagging the boy then things would improve - but it really doesn't affect his life. Again de Shazer tells us that the father in this example needs to "discover" a complaint and become a customer for the whole system to address an individual's problems. In his books he describes a number of ways of converting "visitors" to "complainants" and "complainants" to true "customers."

INTERVENING WITH SUICIDAL YOUNG PEOPLE
BRIEF FAMILY THERAPY

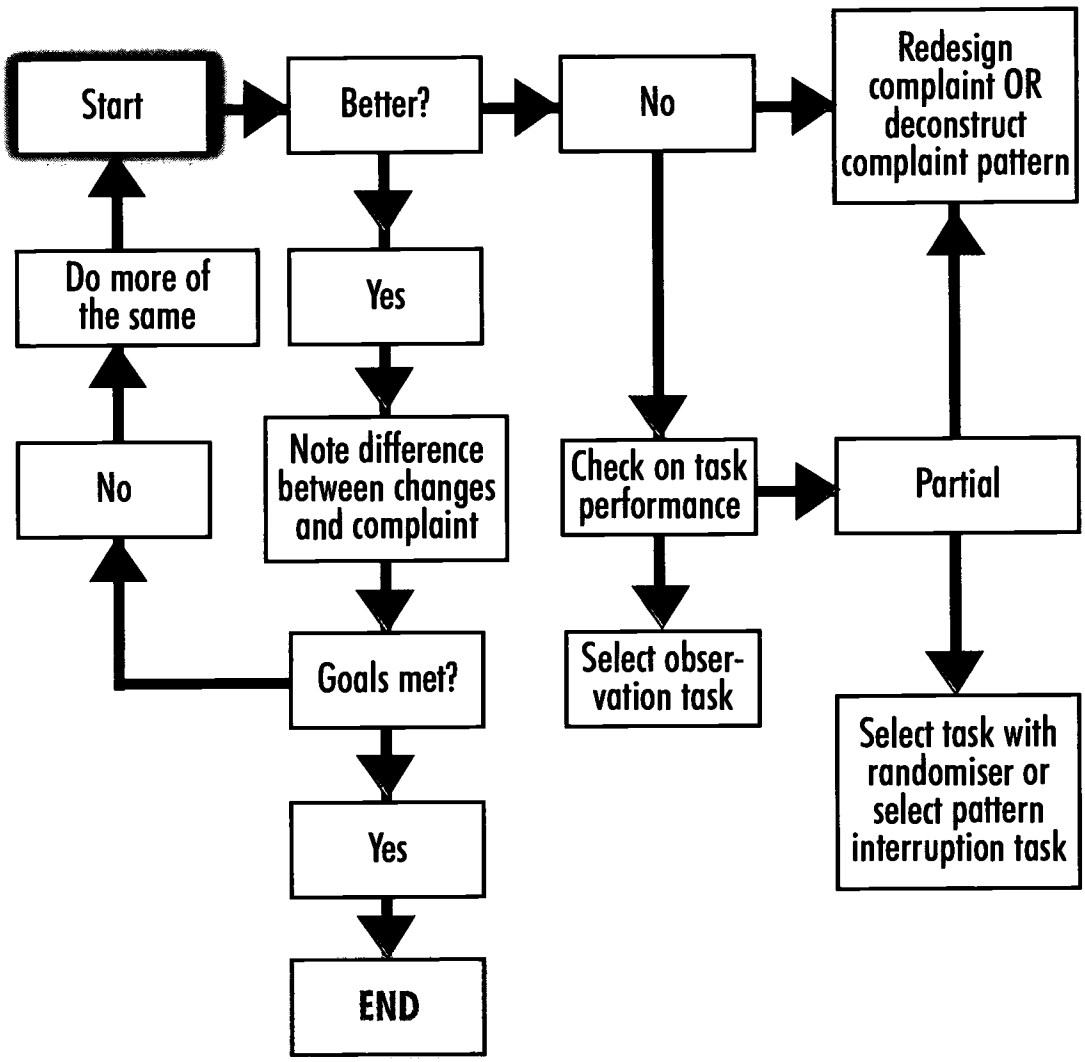
THE FIRST SESSION - DIAGRAM 1



Adapted from de Shazer 1988

INTERVENING WITH SUICIDAL YOUNG PEOPLE
BRIEF FAMILY THERAPY

SECOND AND SUBSEQUENT SESSIONS - DIAGRAM 2



Adapted from de Shazer 1988

BEGINNING THERAPY

The key elements here are the construction of a step by step understanding of the complaint or problem. As part of this we search for "exceptions." When does the problem not exist or lessen; who is involved and what are they doing when the problem goes away. If exceptions exist, even if only for a brief time, de Shazer tells us that this time can be expanded by getting the family to repeat or expand on what it is they are doing when the problem does not exist, ie: when the desired solution (the absence of the problem) is present. It is exceedingly rare not to be able to find some exception, but it is possible to build or imagine a hypothetical solution ("just suppose there was a time...") and explore the detailed step by step involvement of all the others in the system ("So how would Mum react...?" or "So who would be the first to notice...?").

If all else fails, a "formula task" can be given and followed up at a second or subsequent session.

Invariant Task

(First Session)

> "Between now and next time we meet, we would like you to observe, so that you can describe next time, what happens in your (family, marriage, relationship, life) that you want to continue to have happen."

De Shazer provides us with a set of general guidelines for therapy:

1. Note what sorts of things the patients/clients do that are good, useful and effective.

2. Note differences between what happens when any exception occurs and what happens when the complaint happens. Promote the former.

3. When possible, extract step by step descriptions of any exceptions. Find out:
   - what is working?
   - what has worked?
   - what might work?

   Prescribe the easiest.

If some aspects of the exception (or complaint) are random then:
- include something arbitrary or make allowances for randomness in the task.

4. When necessary extract a step by step description of the complaint. This may help in the search for exceptions.
   - So what happens next?
   - How come that doesn't happen every time?

5. Note differences between any hypothetical solutions and the complaint.
   - So if you were to do that, would it make a difference to the problem?
   - How could that be?

6. Imagine a solved version:
   - make exceptions into the rule
   - change location of complaint pattern
   - change who is involved in pattern
   - change order or steps involved
   - add a new element or step
   - increase duration of pattern
   - introduce arbitrary starting/stopping
   - increase frequency
   - change modality or behaviour

7. Decide what will fit for this complainant/customer:
   - Which task?
   - Based on which variable?
   - What makes sense?
   - What is most likely to be acceptable?
   - Which one will they do?

8. Always set achievable goals:
   - Keep it simple
   - Start easy
   - Make sure everyone agrees
   - Always check in subsequent sessions

Successful therapy is not just about technique but clearly involves a good relationship or "fit" with the family. Clearly your ability to listen actively to what is being presented, your capacity for empathy and your understanding of psychological mechanisms and family interaction will all influence how well the task of therapy can be achieved *and* how well you can fit it into a relatively brief time frame. In general, be clear in your communication (open and direct); have a clearly defined goal ("So when we have reached this point we will *all* know we have done what we set out to do ....") and have clearly defined tasks (and homework tasks) to achieve the overall goal.

Don't be too clever - the K.I.S.S. *(Keep It Simple Stupid)* principle is a basic tenet of brief effective therapy.

REFERENCES

1. **de Shazer S,**1988. *Clues: Investigating Solutions in Brief Therapy.* WW Norton & Company, London, UK

COGNITIVE BEHAVIOUR THERAPY

Definition:

Cognitive Behaviour Therapy is a short term focussed counselling approach that uses active methods to alter the way a person thinks about themselves and their current circumstances.

It is based on the premise that thought processes enable people to understand their own reality. When considering depression, these thought processes are faulty and constant errors make interpreting experiences and their meaning difficult. The individual views the world as "black and white", "all good or all bad", and as not allowing any choices in their life. Such thoughts are called *"cognitive distortions"*. There are a number of such distortions as illustrated in Table 1.

This all happens despite the fact that there is no evidence to support these strongly held thoughts and beliefs. Consequently, all of the physical and emotional symptoms of depression stem from errors in thought processes.

In summary the Cognitive theory of depression proposes that the individual has:

- a negative self concept eg "I'm useless!"
- a negative world view eg "Everybody hates me", "Life Sucks!"
- an expectation of continued hardship eg "My life will always go wrong", "Nothing I ever do works out right".

CBT Approaches:

The aim is to test the underlying negative thoughts about the self. To assist the person to redefine their world view into something more positive and to rehearse new and more positive ways of responding to the world and their circumstances. By changing the thinking of the individual to be more positive; more optimistic; it follows that there will be a change in the feelings they experience and in particular, a lifting of the depression.

There are 3 core elements to CBT:

- Didactic Approaches
- Cognitive Approaches
- Behavioural Approaches

DIDACTIC APPROACHES:

It is crucial as part of this approach that the therapist provides the patient with a full explanation of the process on which they are about to embark. They should discuss the underlying theory of depression from a Cognitive viewpoint. This explanation could include the "think-feel-behave" model that was demonstrated in the workshop (refer to workshop diskette). The patient is informed that they will embark on a series of "experiments" to test if the ways that they think about themselves and the world are really valid.

So in this aspect of therapy the aim is to:

- explain fully all the links between thinking and feeling
- explore the link between depression and thinking
- explore the links between feelings and behaviour

COGNITIVE APPROACHES:

The Cognitive Approach involves 4 main areas:

- Eliciting Automatic Thoughts
- Testing Thoughts
- Finding erroneous assumptions
- Testing these assumptions

Eliciting Automatic Thoughts:

In depression and suicidal behaviour there are a number of predominant automatic thoughts. These are:

- a pervasively negative view of oneself, one's experiences and one's future
- an overwhelming sense of hopelessness and an inability to find a way to solve current problems

These may be expressed by the young person in a number of ways and are worth exploring. For example, the young person may say:

"I know s/he hates me because when we passed in the street the other day s/he didn't even say hello."

OR "I came into the room and they started laughing at me!"

OR "It's my fault everything goes wrong at home!"

Testing Thoughts and Assumptions

This is where the therapist asks the young person to find the evidence for these automatic thoughts. This is usually done very directly and then the thought is discussed as to whether it is an accurate or faulty perception. Therefore the therapist assists the young person to find alternative explanations for the experiences that they may have suffered.

Using the examples above:

- The true explanation of why the person didn't notice him/her was because s/he was distracted by something else.
- They were laughing at a joke as the person walked in the room.
- Things going wrong at home could be because other people aren't contributing to the needs of the family.

The young person must be asked to find evidence and prove their position is correct. They must show the therapist by using "evidence" and logical argument, that the statements they make have true validity!

Finding Erroneous Patterns:

As the above two processes proceed it soon becomes clear that there are repetitive patterns emerging. The young person has adopted a consistent and yet flawed way of looking at their experiences, providing a "negative prescription" for life. The outcome is then depression and suicidal behaviours. See **Table 1**.

FAULTY THINKING OR COGNITIVE DISTORTIONS

TABLE 1

FAULTY THOUGHT PROCESS	DESCRIPTION
1. All or Nothing Thinking	Everything is black and white. If things are not perfect then the person sees themselves as a total failure.
2. Over-Generalisation	A single negative event or outcome is seen as an ongoing pattern of failure.
3. Discounting the Positive	Any positive experiences simply do not count, for whatever reason. This means it is easier to hang on to all the negative thoughts.
4. Jumping to Conclusions	Anything is interpreted in a negative way. The assumption is that everyone reacts negatively to you as an individual and this is not clarified or it is anticipated that things will go wrong and when it does it reinforces the negative self assessment.
5. Mental Filter	A single negative event or outcome is dwelt on which eventually colours the entire perspective of life.
6. Magnification or Minimisation	The importance of the negative things that the individual does is exaggerated whilst the positive things are down played.
7. Emotional Reasoning	The idea that negative feelings are really the way things are.
8. Should Statements	A series of self punishing statements are made such as *"I should..."* or *"I ought..."* The consequence is feeling guilty or when others don't do what *"They should..."* feeling angry and frustrated.
9. Labeling and Mislabeling	This is when a highly emotive form of over generalisation is used. *"I'm an idiot!"* or when directed towards others *"She's a pig!"*
10. Personalisation	Any negative event is automatically assumed to be that individual's personal responsibility.

Adapted from DD Burns 1980

Testing Erroneous Patterns:

The role of therapist here is to begin to point out these repetitions and show the young person the link between their "negative prescription" and their current emotional state. Again the young person must provide the evidence that the patterns are valid and must defend their patterns. It will soon become clear that the patterns are not defensible when challenged. To a young person who states that they never do anything right, the therapist could ask:

"So why do you so strongly believe that you never get anything right; you got here on time, didn't you?" OR "Why do you believe that, when you have done the right thing by seeking help for your problems?"

Behavioural Approaches:

There are a number of behavioural strategies that can be used as part of CBT:

- Scheduling Activities
- Mastery and Pleasure
- Graded Task Assignments
- Cognitive Rehearsal
- Self Reliance Training
- Role Playing
- Diversion Therapy
- Imagery - directed and guided
- Thought Stoppage

Scheduling Activities:

This may be done by asking the young person to set aside a specific time each day to undertake a given set of tasks or "homework". For example, for the young person who feels that their world is crowding in on them and they feel very anxious out of the home, they can be asked to schedule a time every day where they must be out of the home for (say) 10 minutes. Alternatively for someone who is overcome by grief and are bursting into tears at any time during the day, they could be asked to set aside some specific grieving time and allow themselves time to cry in a safe place (See section on bereavement for more exploration of this issue).

Mastery and Pleasure:

In association with scheduling, this is done by asking the young person to rate how much mastery and pleasure their activities bring (scaling is a useful method in this process). For the young person afraid to leave the house, there may not be much pleasure but could be a significant amount of mastery. For the grieving person, they may find mastery over their grief by controlling it to a predictable time and in fact gain some relief from their intense negative feelings (hence pleasure). This does not have to rely solely on the problems the young person is faced with; it can be used for everyday events and activities. For example, the young person could be asked to rate the level of mastery and pleasure that they get from listening to their favourite music when scheduled at a particular time or playing some sporting activity, again, when specifically scheduled.

Graded Tasks:

To show the young person that they can achieve and accomplish goals, it may be necessary to break tasks down into small components. The aim is to give them a sense of optimism in their own abilities to tackle difficult problems. For example, a young person who finds it difficult to stop arguing with their parents may be asked to do the following:

Every time you feel like getting angry with your parents I want you to take two deep breaths, take a step back, sit down, count to ten, say "Can we talk about this when I am not feeling so angry?" and leave the room.

Clearly parental co-operation would be needed! It may be that the young person can only achieve steps one and two but at least this is a beginning!

Cognitive Rehearsal:

In this approach the young person is asked to imagine in their mind how it would be if they behaved differently in a given situation; to imagine an alternative way of reacting and behaving. They are also asked to practice these alternatives, "replay" the scenarios that show them beating their problems, or overcoming their depression.

Self Reliance Training:

This is as simple as it sounds: the young person is encouraged to take care of themselves in activities of daily living. Again, the co-operation of the parents or those in their living situation, is essential to this. They must not rescue the young person from their household responsibilities because the young person is going through an emotional crisis. Doing so robs the young person of simple ways in which they can regain mastery and pleasure for themselves in their own activities and care of themselves.

Diversion:

Diversion is a simple approach to distract the young person from their intense feelings. Physical activities, sport, exercise, hobbies, relaxation, meditation, music or anything that the young person has previously gained pleasure from, is useful.

Role Playing:

This can be used in a number of ways:

- to elicit and test automatic thoughts and assumptions
- to learn new ways of responding to situations.

It can also be used in "role reversal":

- to allow the young person to play the role of another significant player in their lives. By playing the other person they have the opportunity to experience how that person may have felt. (this is commonly referred to as psychodrama or action methods)

Imagery/Visualisation:

This technique is well recognised in the sporting arena as "psyching up to an event". The young person can be asked to visualise how they would be if they were not depressed and suicidal. How would they look? How would they feel? What would they be doing? How would they walk? How would they talk to others? How much would they drink or take drugs? The more detailed the imagery, the better the potential to influence current thinking patterns.

Thought Stoppage:

This is a conscious and rehearsed message to stop a particular thought and subsequent behaviour. For example if the young person is having a thought that says to them "turn up the music to really annoy Mum and Dad", they could be asked to imagine the lead singer of the band saying, "Too loud and you won't be cool" (or whatever the appropriate excpression is - the young person can help you find the right words.) It is important for them to find the right "Stop Sign" for the thought.

Summary:

Cognitive Behaviour Therapy (CBT) has a range of active and participatory strategies that make it appropriate to use with young people. Each technique can be used in isolation or in combination with any other and it provides the health professional with enough variety to ensure that the young person is fully engaged in the counselling process.

REFERENCES

1. **Hawton, Salkovskis, Kirk, Clark,** 1989. *Cognitive Behaviour Therapy for Psychiatric Problems.* Oxford University Press, London. Especially chapter 6 on Depression. Gives basics and fundamental outline of CBT suitable for general practitioners and other health professionals.
2. **Wilkes, Belsher, Rush, Frank.** 1994. *Cognitve Therapy for Depressed Adolescents.* The Guilford Press. Adjunct to above and gives further techniques for use by practitioners with adolescents.
3. **Tanner S, Ball J.** 1989. *Beating the Blues.* Doubleday. Straightforward self help book for adolescents. Recommended as overview for GPs.
4. **Burns DD.** 1980. *Feeling Good: The New Mood Therapy.* Signet/Schwartz & Wilkins. Preface by Aaron T Beck. Techniques for practitioners. Also has an accompanying handbook.

NARRATIVE THERAPY: AN OVERVIEW

Theoretical framework

A narrative approach to therapy is based on the idea that *"people's lives and relationships are shaped by the 'stories' that individuals and communities of people develop in order to give meaning to their experiences".*[1] These stories are neither unchanging facts nor self-generated constructions. Narrative approaches are based on a theory of social construction whereby we come to understand and create our realities through language (both verbal and non-verbal) as we interact with other people and the organisational, social and power structures in our lives. Our language and the stories or narratives we develop are not simply reflections or representations of our lives, they shape and construct our lives. Epston, White and Murray (1992) have stated that,

> "Story or narrative provides the dominant frame for lived experiences and the organisation and patterning of lived experience... It is through these stories that lived experience is interpreted. We enter into stories; we are entered into stories by others; and we live our lives through these stories. "(p.97)[2]

Stories involve a temporal dimension; they shape and reshape our histories, our present and our futures. As Bruner (1986) has stated, story or narrative deals with the vicissitudes of human intentions.[3] Each telling can be shaped by a different intention and produce a different possible history, present and future. It is not necessary to have a different teller in order to have a different intention, nor the same teller for the same intention. Narrative therapy can address the multiplicity of meanings available for any experience according to different witnesses or participants of an experience or different frames of reference for viewing it. It invites people to take up a role of "reauthoring" their lives in conjunction with the therapist, rather than having other people, problems or dominant societal beliefs author their lives for them.[4/5]

This means it is not possible for a single narrative to encompass the richness of a person's lived experience.[6] Any narrative is but one way of describing or constructing the meaning of those lived experiences, however, a narrative can become dominant over others and become viewed as the only or main story about a person's life. Those experiences that fit with the narrative are selected out as being of most significance and those that do not fit are ignored or discarded. It is the experiences that do not fit, often called unique outcomes, that open up therapeutic possibilities for people re-authoring their lives by different narratives. It is these experiences that a therapist will be very curious about as they form a foundation for the alternative story.

A narrative approach to therapy means that the dominant story that a person is currently living out can be explored, pulled apart and questioned (often called deconstruction). Experiences that do not fit with the dominant story can be identified. An alternative story based on these unique outcomes can then be constructed that takes the person in a preferred direction in life.[5] This approach has wide application in counselling. It has significant appeal to young people as they understand how they can help develop a different story about who they are and invite important people in their lives to view them through this different story.

For young people struggling with the idea of suicide and plagued by hopeless and worthless thinking, a story of self-destruction or giving away one's life, narrative therapy can help reconnect them with their experiences of competence, survival and hope. These reconnections can invite them into an alternative story of self-worth, courage and purpose so they can choose life and not feel compelled to respond to suicide's call to death. Clearly this is not achieved in one or two short sessions, although the process can gain a solid start. It does need support from a trained therapist.

In the video, the GP became curious about what assisted Bridget to hold onto life just at the time when the call to death was strongest. This opened the door to reasons for choosing life and began to identify Bridget's personal resources that she could put at the service of a future rather than losing them to hopeless and worthless thinking. This established the threads of an alternative story that future therapy could encourage Bridget to expand upon.

The GP did not fall into the trap of trying to *replace* Bridget's account of her life with her own professional account and impose these meanings on Bridget. She acknowledged the expertise that Bridget had about her own life and offered her thoughts and asked questions from a place of curiosity. In this way, she began *co-constructing* an alternative account that could be placed alongside Bridget's dominant story and the GP's assumptions about what may be happening as an equally valid understanding.

As the conversation developed, the GP would be able to find out which account or story about her life Bridget preferred to hold. It is likely that the co-constructed account would be more appealing as it focused on Bridget's resistance in the face of adversity and her survival of adverse circumstances. This had not been the way many people had come to view Bridget. Others saw her as a street kid getting into trouble rather than a young person struggling to find a way to survive.

Externalising Practices in Narrative Therapy

A major component of narrative therapy which was described in the video is the use of externalising conversations.[4/7] Externalising is the process of separating a person from the problem he/she is experiencing and naming the problem as a separate entity to the person. When understanding the place of a problem in a young person's life, we need to consider both the impact the problem has for the young person and family or system and the impact that the young person and family or system has on the problem. This helps us to see what the young person and others find themselves doing due to the presence of the problem, as well as the times when they escape the effects of the problem for long enough to feel more in charge of their lives.[4/6] [The family or system includes whoever are significant people in the young person's life, such as peers, teachers, adult friends or workers, and is not defined by biological relationships.]

If we map what effects a problem has had on the life of a young person and their significant others it is possible to create a separation between their personhood and the problem they are experiencing. This is very different from collapsing the young person into the problem so that his/her own identity disappears and inadvertently blaming the young person for the situation in which he/she finds him/herself.

As a simple example, if we describe people as being something stated as a noun, we indicate a static state that is unchangeable and thus, we diminish hope for change. We do this with language such as saying, "That kid is a conduct disorder, an ADHD kid, or a suicide risk". Suddenly, when we look at the young person, that is all that we see. Alternatively, we can use verbs such as "seem, show, behave, act, experience" and describe the person with an adjective. For example, "he is acting insecure" vs "he is insecure" or "she is showing suicidal behaviour" vs "she's a suicidal kid." In this way, we are indicating that this does not need to be a permanent feature, nor the only feature characteristic of this person, but one relating to his/her current context.

Externalising conversations are developed by listening closely to the language and metaphors used by the young person. The therapist can then try out possible externalised descriptions of the problem to see if they might fit for the client and/or invite the client to name the problem. In the video, Bridget and the GP began referring to "The Depression" as "Bad Feelings." However, they may have talked about "Shitty Moods," "The Blues," "The Voice of Death" or "Hopeless Thinking." More than one externalisation can be used at a time. Sometimes there is not a specific externalisation, but an externalising conversation is still held about the sort of ideas that would support giving away one's life, using violence or feeling worthless for examples.

Questions which Elicit Dominant and Alternative Narratives

The GP in the video began to get a sketch of the "problem-saturated" story for Bridget, also known as the influence of the problem on the person's life. It is important to understand what has been happening due to the presence of the problem. A range of questions would be asked, such as:

- What has the problem invited Bridget to think about herself?
- How has the problem invited her to act towards herself and others?
- How has it shaped other people's views of her?
- How has it encouraged people to act towards her?
- What has the problem encouraged her to do about her circumstances?
- How has it intruded on her own plans for her life?
- What has it taken way from her that she may want back?

Please note, this is not meant to be an exhaustive list. Further, you would replace "the problem" with the name that has been given to it. Some "deconstruction" questions[5] would also help illuminate how the young person has been "recruited" into the problem and finding him/herself dominated by it. For example:

- Where would the problem have developed/learned these ideas about Bridget?
- How did the problem start to gather strength?
- What did Bridget or others need to believe about her to strengthen the problem's hold on her?
- What things did Bridget find herself doing that would have convinced others that she was caught up in the problem?
- What do people in the community think about young people that would have supported the problem's view of Bridget? How accurate or fair are these ideas?

As the story emerges, it is likely that there will be things that don't fit into the dominant or problem-saturated narrative. Asking about these unique outcomes will identify the ways in which the person has had an influence over the problem and resisted what the problem has required of his/her life. For Bridget, this included caring about her young brothers and worrying about how to protect them and prevent them from going through her experiences, finding ways to survive on the streets and coming in to see the GP.

Questions that might be asked include:

- When has Bridget prevented the problem from encouraging her to take her life?
- What happened at that time (where was she, who was she with, what went through her mind, what was she saying to herself, etc)?
- What did she believe about herself at this time?/ How did this push the problem away?
- Who might have noticed her doing this?/ What would they have thought about her achievement?
- What qualities or special abilities did she draw on to push the problem away?
- Where had she learned or how had she developed these qualities/special abilities?

As the young person responds, the beginnings of an alternative story become evident. This is a story in which the young person has some skills and qualities that allow him/her to be in charge of the problem or have a more positive relationship with it compared to the problem directing and organising his/her life. The young person is often invited to take a stand on which direction he/she would like his/her life to go. In Bridget's case, this was between a life of Depression that would lead her to an early death, or a life of courage and caring where she could have a positive influence in her own and her brother's lives.

Summary

These basic components of a narrative approach to therapy do not necessarily happen in an orderly fashion, one stage after another. There is often overlap between the components during any conversation and it is often helpful to revisit the components as therapy continues, particularly the deconstruction questions and the influence of the person over the problem. Problems are used to taking up a lot of space in a person's life and having a strong influence over their self-description (and other people's description of the person), so they do not give up easily on this position, especially when they have a long history in a person's life. It takes considerable effort at times for people to reauthor their relationship with a problem and strengthen their preferred story about life, especially for young people struggling with suicide. A narrative approach to therapy does not have to be a long affair, it can take place over a relatively brief period of time. However, engaging in a narrative revisioning of self and relationship requires good support, both from a trained therapist and other significant people in a young person's life. A GP can be one of these people.

Final Note: There are many other practices involved in a narrative approach to therapy which could not be addressed in this brief description - please refer to the references, further reading and training programs for more indepth information.

REFERENCES

1. **McLean C,** 1995. *Narrative therapy and its role in the project: Speaking out and being heard.* Dulwich Centre Newsletter, 4, 7-9.

2. **Epston D, White M, Murray K,** 1992. *A proposal for a re-authoring therapy: Rose's revisioning of her life and a commentary.* In S. McNamee & K. Gergen (Eds.), Therapy as Social Construction. Newbury Park, California: Sage.

3. **Bruner JS,** 1986. *Actual Minds, Possible Worlds.* Cambridge, MA: Harvard University Press.

4. **White M,** 1989. *The externalising of the problem and the reauthoring of lives and relationships.* In M. White, Selected papers, Adelaide: Dulwich Centre Publications.

5. **White M,** 1991. *Deconstruction and therapy.* Dulwich Centre Newsletter, 3, 21-40.

6. **White M, Epston D,** 1990. *Narrative means to therapeutic ends.* New York: Norton & Co.

7. **Denborough D,** 1996. *Notes on externalising problems: Commu-nities respond to HIV/AIDS, Diabetes and Grief.* Dulwich Centre Newsletter, 3, 36-38.

FURTHER READING

1. **Freedman J, Combs G,** 1996. *Narrative therapy: The social construction of preferred realities.* New York: Norton & Co.

2. **White M, Epston D,** 1990. *Narrative means to therapeutic ends.* New York: Norton & Co.

RESOURCES

TRAINING PROGRAMS IN NARRATIVE THERAPY

1. ***Dulwich Centre***
   One week intensives, Graduate Certificate (1 year) & Graduate Diploma (2 years) both part-time Carrington Street, Adelaide SA 5000
   TEL: 08-8223 3966 • FAX: 08-8232 4441

2. ***Contemporary Therapy Collective***
   Short course, 12 weeks x 3 hours (focus on narrative and solution-focused therapies)
   Box 1061, St Kilda, VIC 3182
   TEL: 03-9534 7288 OR 03-9509 7805 OR 015-813 745

3. ***Macquarie University*** Certificate course over 1 year part-time
   Macquarie University, North Ryde, NSW 2113
   TEL: 02-9850 8019 OR 02-9974 5847

FURTHER GENERAL PRACTICE TRAINING IN COUNSELLING SKILLS

Graduate Diploma in General Practice Psychotherapy
Department of General Practice, University of Adelaide
North Terrace, Adelaide, SA 5000
TEL: 08-8303 3450 • FAX: 08-8303 3511

FURTHER TRAINING IN COUNSELLING SKILLS FOR COMMUNITY HEALTH WORKERS

Graduate Certificate in Health (Primary Health Care)
Masters in Primary Health Care
Master of Science (Primary Health Care)

Each of the coordinated courses has a specialist stream in Community Mental Health with topics in aspects of counselling and therapy.

Department of Public Health
Flinders University of South Australia
Bedford Park SA 5042
TEL: 08 8204 5412 (Mr Clive Skene, Ms Kathleen Stacey)
FAX: 08 8204 5465

OVERVIEW - BRIEF GUIDE TO MANAGING BEREAVEMENT

- Contact the family immediately you hear of the suicide in order to offer your sympathy and support. A home visit may be the most appropriate way of assessing the family's needs. Many later misunderstandings may be prevented by an early visit.
- If you are called to certify death, instruct the family to leave everything as they found it. Explain the necessity of referring to the Coroner and the reasons for the post-mortem, including the likely effects on the body. Explain that the police will need to investigate and will require statements from the family. After consultation with the police, arrange an opportunity for family members to view their loved one alone, if they wish, before the body is taken away.
- Make sure the family have a close friend or relative with them for the first few days. You may need to contact other persons who may be able to help them such as their priest, minister or spiritual adviser.
- Should it be necessary to prescribe medication to alleviate the initial shock, a single dose of a hypnotic may be appropriate and will be unlikely to dull the senses afterwards so as to enable full participation in the preparation of the funeral rites.
- Arrange a future meeting to discuss:
  - practical support
  - health care
  - grief reactions
  - information from other sources such as the Coroner's Office.
- Recognise your own grief reaction and discuss it with a colleague.
- Continue support as appropriate, especially around significant spiritual and cultural events eg Christmas, New Year, Mother's Day, Birthdays and the anniversary of the death.
- Families may wish to see the post-mortem report. The GP is entitled, in most States, to apply for the report in writing on behalf of the next of kin in order to assist them in understanding it. When making such a request, the letter needs to be accompanied by a written authorisation from the next of kin or close relative.
- Families may have particular concern about the risk of suicide in other individuals. Explanations about the causes of suicide and mental illness may assist.

Intervention by the general practitioner is important in:

1. assisting the bereaved;
2. preventing secondary physical and psychiatric morbidity;
3. preventing further suicides.

WHY IS THIS AN ISSUE?

Around 10,000 people suffer the death of a close loved one through suicide in Australia each year. For each person who dies it is estimated that at least five others are severely affected with grief. In addition there are those who are frequently forgotten, but who are also affected by the death. These include more distant relatives (aunts, uncles, cousins), friends and the various work associates and helpers of the person who took their life. Young people form an important group as they may themselves be bereaved through suicide of a sibling, parent, friend etc as well as being indirectly affected because of grieving parents.

Grieving is a long process and bereavement reactions can continue for 5 years or more after the suicide depending on the closeness of the attachment to the person who has died. At any one time the population grieving a loss through suicide in Australia may be 50,000 or more.

Suicide of a patient of any age occurs every 4 to 5 years in any full time general practitioner's practice. This number will be greater if the GP has an interest in mental health issues. At any one time a general practitioner's practice is likely to include 4 or 5 patients bereaved through suicide.

Suicide carries several of the risk factors for complicated grief:

- the death is unexpected, untimely, horrifying, and the dying process may be painful;
- there is usually a perceived cause for blame on the bereaved;
- commonly occurs on a background of disturbed family dynamics as a result of symptoms of mental illness;
- families affected by suicide may also be struggling with other issues such as sexual abuse, alcoholism, homosexuality etc;
- death of a child results in a more severe grieving reaction for the parents;
- familial depression may complicate the grief process.

POSTVENTION IN THE COMMUNITY

Postvention is a term which covers the whole range of intervention after a suicide. However, working with the bereaved is covered thoroughly in this manual, and the remaining issue of working with the community following a suicide is the content of what will be covered in this section.

A Case History:

> *David is a charge nurse in a large city hospital. About three months after Michelle died (see "Youth Suicide: Recognising the Signs"), David was at our home with a group of young people lounging around listening to music. Quite casually he said: "Did you hear about that young woman who jumped from the car park on North Terrace about three months ago?*
>
> *She landed about 10 feet away from me ..."*
>
> *At this point, David burst into tears describing his experience at the time, and how it had affected his work, his study and his social life. David had been unable to tell anyone because, as a professional, he had felt he should be able to cope on his own. But this dramatic act intruding into his life had caused so much difficulty and his grief (that of a total stranger) was severe.*
>
> *None of the other professionals (ambulance, police and doctors) had thought to ask passers by if they could cope.*

This case history graphically describes the impact of a suicide and shows that grief is not just confined to the immediate family.

Of particular concern are close friends of the deceased in the few days after a suicide. Particularly in a school or other semi closed environment, acquaintances in the immediate social circle will all be affected. Three groups must be considered:

1. Amongst the immediate friends there are always a few who will have discussed suicidal thoughts and behaviours with the deceased prior to death. Some of these will be particularly distressed. If they have personal or social or family problems of their own or have a previous history of emotional problems not only will they grieve, but some may be influenced by the death and prone to copy the act of the deceased.

We would recommend that immediately following a suicide, you bring together key staff from the school (or college, etc.) and decide on a plan for immediate action. In particular this must seek to deal with grieving friends and classmates but also seek out those who may be vulnerable to copycat suicide. A carefully co-ordinated management plan in association with family and friends may well be preventive of further difficulty.

2. In addition, amongst a group of teachers or other professionals in such an environment there will always be one or two severely affected by the loss. Again, one or two may have a relevant mental health history and will need special care and support. The school will wish to return to education and the normal routine as soon as possible. Supporting grieving staff will speed up a healthy return to a functioning environment.

Few other professionals, particularly in a rural or remote environment may be able to take over this coordinating role. Early detection and appropriate intervention are the keys to prevention in the context of suicide.

3. Finally, parents of other young people are likely to have concerns for their own and a discussion group or workshop may serve to bring anxieties to the fore and provide the opportunity for informed opinion and clear planning for future problems.

It is appropriate to think this through broadly, given the impact of suicide on David (see above). The suicide may be given meaning if these actions are adopted to prevent future mental ill health in others.

As a final note, one stage of grief may cause a problem in addressing these issues - that of "Denial." Many professionals will not want to explore their own response and may attempt to avoid public discussion, urging immediate "return to work!" This needs to be handled with care, but does not promote recovery of the individual or the system in the long term. A simple explanation that good mental health is necessary for individuals in the school or college to learn well may assist in allowing open discussion, clear planning and an awareness of possible future difficulties for all concerned.

THE LANGUAGE OF BEREAVEMENT AND POSTVENTION

- Use *'take their life'* or *'suicided'* (although not grammatically correct) instead of *'committed suicide'* to avoid reference to a crime. Until recent times suicide was regarded as a criminal offence. Care with language helps avoid such stigma.
- Use *'bereaved'* rather than *'survivor'*. *'Survivor'* is more frequently being used to refer to those who attempt suicide and survive.
- Avoid sayings and metaphors which include reference to methods of suicide or to death
  eg: I need it like a hole in the head.
  A shot in the dark.
  I'm dying to see it.
- Advise adults to use the word *'dead'* when talking with children and to avoid the term *'asleep'* otherwise children may associate the two which may lead to bed time phobia.

THE GENERAL PRACTITIONER'S RESPONSE TO A SUICIDE

Notice of the suicide of a young person may come in many forms such as from the Coroner's office or from family or friends. Country GPs in particular may be required to attend the site of the suicide and confirm the death. Your own grief process must be acknowledged before you can offer support to your clients.

Make time to acknowledge and work through your own reactions:

1. These may include shock, horror, guilt, professional and personal failure, shame, sadness and anger at the disruption.
2. Remember that grief is an individual experience and may even bring to the surface past unresolved personal grief. It is important to recognise these feelings are normal and work through them.
3. The dilemma is in dealing with personal feelings at the same time as facing up to meeting the grieving family.
4. Do not be tempted through pressures, such as a heavy workload, to sweep the whole thing under the carpet - this will not help you or your patients.
5. Other doctors also feel distressed but because these issues are rarely talked about, they are not common knowledge. Confide your feelings to a journal and talk to someone whom you can rely on to keep your confidence:
   - a colleague,
   - family or close friend,
   - the **Doctors' Health Advisory Services** (see list of resources)

The *Doctors' Health Advisory Services* were originally established because of the known difficulties doctors have in seeking help for themselves. The primary function of the services is to assist doctors in distress by providing confidential and non-threatening advice. A doctor who telephones for assistance will be put in contact with a counselling medical practitioner who will listen to them and refer them on to specific help if appropriate. The services are completely confidential. No records of names of callers are kept by the DHAS's and none of the counselling medical practitioners report back about the caller.

6. You and the grieving family may mutually assist each other.

7. Your own lifestyle and supports will be important.
   - time with family and friends
   - time out: fun, hobbies, holidays
   - sense of humour
   - healthy lifestyle; diet, exercise, relaxation
   - sense of purpose in life

REMEMBER: No-one yet has the complete answer to identifying potential suicides. It is important not to be destroyed by the experience, but to incorporate what you have learned into your future practice.

IMMEDIATE ASSISTANCE FOR THE FAMILY

IMMEDIATE SUPPORT IS ESSENTIAL:

A visit to the family can be an invaluable catalyst for the family's recovery. It is an opportunity to provide support and information and helps the family believe in themselves again. It also demonstrates to all present that you are an appropriate source of help for the future.

Preparing to meet the family you will need to:

- put your feelings on hold and deal with them later;
- be objective; remember the family need your help;
- establish a convenient time in your day's schedule and telephone immediately you hear the news to let them know you will visit that day.

Your role is to:

- be there and listen;
- respond from the heart;
- assure them that they are normal;
- pay attention to other children in the family;
- offer ongoing support;
- remember, should the family respond with anger, that this is a normal part of grief but may make your job more uncomfortable. Listen to them empathically and allow them to vent their emotions;
- be prepared to answer questions and provide advice (see below).

Some common questions are:

- why attempts at resuscitation were stopped, not begun or further resuscitation would not have been effective;
- about the coronial process (You will need to help them understand that the purpose of the police is to investigate and document the manner, cause and circumstances of the death);
- about the effects of the post mortem on the body.

IMMEDIATE ADVICE

VIEWING THE BODY

1. Offer the family opportunity to view the body.

Location: This may be done at:

- the site of the suicide (often the most important to the family because of the closeness in time and place to the living);
- the local mortuary;
- the funeral director's viewing room. This may be the most aesthetically desirable. Funeral directors are very skilled at making the body (or part of it) presentable, even if severely mutilated.

Purpose of a viewing:
(important because of the suddenness of the death):

- to say goodbye;
- to establish the reality of the death;
- to debunk fantasies about the identity of the body and trauma done to the body from the mode of death;
- to establish the deceased is at peace. Bereaved people often comment that seeing a peaceful expression on the face of their loved one after death helps them realise the loved one is released from their emotional pain. This often helps the bereaved come to terms with the death.

2. Prepare the family regarding the condition of the body:

- colour;
- cold to the touch;
- post mortem scars;
- trauma from the mode of death.

3. **Ensure support:**

   Most Coroner's offices now have a social worker or a counselling service to assist and accompany newly bereaved persons to a viewing at the mortuary. Funeral directors themselves will do the same.

4. **Children and viewing the body:**

   Assist the adults in offering children opportunity to view the body and help them prepare the children for it. Encourage but never force the children to view.

5. **Choosing not to view the body:**

   In cases where the family choose not to view the body, arrangements can be made with the funeral director to take photos of the body to be kept on their files. These may assist later in dispelling distressing fantasies.

WHAT TO TELL OTHERS:

- **Tell the truth about the cause of death up front.**

This is easier in the long run rather than fabricating a story which in the end may lead to greater complications. For some people there is still a lot of stigma attached to suicide. Education about causes of suicide can do a lot to dispel stigma. The bereaved may find it useful to give their friends the information leaflets: ***Helping Friends And Relatives Who Have Been Bereaved Through Suicide*** which can be detached from the back of the book by Dr Sheila Clark ***After Suicide: Help For The Bereaved.***

WHAT TO TELL THE CHILDREN:

- Tell the children the person took their life without going into any details about methods used. Say the person is dead without using the word asleep.
- Ask them what they understand by dead and correct them if they think it is not a permanent state.
- Children may need clarification about the term *'took their life'* in which case they need explanations such as *'ended their life'* or *'killed themselves'*.
- Establish that taking one's life is not a solution to problems and everyone is very unhappy that the person did this (the person who took their life will usually be older than the child and be looked up to as a role model).
- Make reference to the reason that the person was unhappy and explain that this may be a form of illness but that even with this form of illness there is a way out through asking for help.
- Establish that the child knows where to go for help.
- Encourage the child to share their feelings with adults.

Here is an example:

Jimmy has died.... He took his life....
He was very sad. It was part of being sick.....
He needed help but didn't know how to ask for it....
He couldn't see any way out of his sadness so he decided to end his life.....
We are very sad he couldn't ask for help because that is not a way out of problems....
We would have liked to have helped him but his suicide stopped us doing that.
If you were ever very sad who would you ask to help you?....
Does it make you feel very sad that Jimmy has died?

ADVISING ABOUT THE FUNERAL

Encourage a public funeral to:

- say goodbye;
- acknowledge the reality of the death;
- give tribute to the person who died;
- provide opportunity of support from others;
- provide opportunity for other significant mourners to grieve; eg: friends, teachers, work colleagues etc.

If the funeral is private, or as sometimes happens there is no funeral at all, complications may arise in the grieving process.

Your attendance at the funeral:

- can be a significant expression of support;
- may assist your own grieving process;
- can also lead to further opportunities for postvention.

SUPPORT

1. Reassure about the normality of the bereavement experiences. The new and passionate emotions combined with the normal illusions of bereavement (thinking they hear or see the dead person) may cause the bereaved to think they are going mad.

2. Educate about the normal process of grieving.

3. Advise regarding practical help from the community. Include advice about enlisting help; every bereaved person needs at least five people who may assist them in different ways, eg provide meals, listen to them, take them out.

4. Educate about lifestyle:
   - regular daily routine;
   - diet - especially regarding caffeine, smoking and alcohol intake;
   - exercise - this may assist sleep, relieve feeling of anger, and induce the much needed endorphins for raising the mood. A walk amongst nature calms the mind;
   - relaxation, meditation and massage.

5. Inform about making no major life changes before the first anniversary of the death. Sometimes families are anxious to move house to avoid associations with the suicide. This often results later in the realisation they have sustained another loss; the memories and associations of the place their loved one knew.

INITIATE GOOD GRIEVING HABITS:

- regular 'grief time' to contain the grief;
- keep a diary to record feelings and memories of the loved one;
- have time out from the grieving; sport, social occasions, time for favourite interests. Grieving people may refrain from pleasurable activities for fear they should not be seen to be enjoying themselves when grieving. Also following suicide stopping all forms of entertainment may be a form of self induced punishment.

MEDICATION

Hypnotics and tranquillisers:

- may provide a necessary respite from the horror on the first night after the suicide;
- should always be prescribed cautiously;
- should be avoided in the lead up to the funeral and for the funeral itself. These are very important times of the grief process in which grieving is initiated and which require full alertness. These are times which can never be replayed. If the senses are dimmed through medication, complications in the grieving process may arise. Patients appreciate these explanations;
- because of their addictive properties and grief being a chronic process, are not advisable except in the very short term;
- pre-sleep relaxation routines and explanations that sleeplessness is normal in grief are accepted by most patients. Some sleeplessness is advantageous as much of the work of grieving is accomplished in the still small hours of the night. Requests for medication are frequently cries for help which need exploration.

Antidepressants:

A distinction needs to be made between normal sadness which includes the deeply painful emotional reactions of bereavement and clinical depression. Clinical depression may be difficult to diagnose because many of its symptoms are common with those of grief, such as insomnia, loss of appetite, difficulties with memory and concentration, and social withdrawal etc. Antidepressants cannot assuage the pain of grief. Depression which may be responsive to antidepressants should be suspected when:

- the person's mood stays continuously low without the normal oscillatory swings;
- psychosomatic illness results;
- there is total preoccupation with the deceased.

Depression may arise in response to the emotional trauma of the suicide and the events leading up to it (see 'Chronic Grief'). It may also be an exacerbation of endogenous depression which may or may not have been severe enough to have been diagnosed previously. Because depression runs in families, the suicide of a severely depressed person may bring to attention depression in other members of the family.

The newer antidepressants, the selective serotonin re-uptake inhibitors (SSRIs) and analogues, are probably at least as effective as the older Tricyclic antidepressants, but are preferable because of their safety in overdose.

THE SUICIDE NOTE

- This is regarded as the precious last writing of the person who took their life. The original note may be held by the coroner until the matter is completed. A copy is given at the time of death to the person to whom it is addressed.
- Some notes may contain derogatory and even accusatory statements about a family member or friend. The persons to whom these are addressed will need special support and help with interpretation of the meaning of these notes. When counselling a person about the contents of a note it may be helpful to remind them that it was written at the time the mind was severely disturbed and the writer's version of the situation is not necessarily the truth.
- Some notes omit thanks and tribute to significant persons. Such an omission may be an indication of the confidence the deceased person had in the relationship.

THE CORONER'S OFFICE

The Role:

The role varies between States and most have a counselling service. Generally the role is:

- to determine the manner, cause and circumstances of the death;
- counsel the next of kin about the death and provide support;
- form recommendations which may lessen the likelihood of further similar deaths;
- provide information about the coronial system;
- provide information about suicide notes to those to whom the note is addressed.

The Coroner's report:

- usually takes several months to finalise;
- may be accessed by the next of kin by making such requests in writing to the Coroner's Office;
- not every patient wishes to see but if they do you will be able to support them through it. Alternatively you can offer to go through the report on behalf of the patient;
- States vary about the method of accessing the report and it will be necessary to check with your local Office. The doctor can generally apply for a copy of the report with written permission from the next of kin;
- Some of the common issues with which the report is likely to help the patient are:
  - How did they die?... Were drugs or alcohol involved?
  - Why did they take their life? ... Might they have been concerned about cancer or AIDS?
  - Was the dying process painful?
  - If the dying process was slow might they have changed their mind midway and been unable to extricate themselves?

THE FUNERAL DIRECTOR

The Role is:

- in the preparation and fulfilment of the funeral rites;
- to support and assist the bereaved around the time of the funeral. Some companies provide on going counselling and bereavement education;
- to provide viewing of the body as required by the next of kin.

In cities there is generally a range of funeral companies to choose from who offer a range of services at various costs. Advise the bereaved family to check about costs. If the family cannot afford a funeral, they may apply to the state social services.

THE FUNERAL

(see also under 'Immediate assistance to the family')

The funeral is to benefit the bereaved. Advise the family to:

- keep the cost in keeping with their wishes and financial resources;
- Advise the family to offer opportunity to everyone who was close to the person who took their life to contribute to the funeral preparations including the other children.

GRIEF REACTIONS - AFTER SUICIDE

The grieving process is like a journey in which the bereaved individual works their own individual route at their own pace. It is complex as there are a large number of new and passionate feelings and questions which can overwhelm them. The grief map may provide a means to helping your patient understand how they feel and recognising these feelings are normal.

The common feelings of suicide bereavement are shown as triangles on the map. The triangles represent mountains. The concept of mountains is used to convey the positive achievements of the grieving process - that effort and work are needed to overcome a particular emotion similar to climbing a mountain. The bereaved person can identify the issues with which they are currently dealing. This may be important in assisting them recognise their progress, raising self esteem and helping them regain control.

Grief Map Instructions:

Ask the patient to:

- underline the phenomena they are experiencing;
- cross out the phenomena which do not apply to them;
- name phenomena particular to them on the unlabelled 'mountains' (triangles);
- fill in the relevant 'mountains' to indicate the height they perceive they have reached. (This will mark their progress).

THE GRIEF MAP - DIAGRAM 3

GRIEF REACTIONS - THE LONGER TERM ISSUES

Important points are:

1. The four month trough is a common feature of bereavement. This can be one of the most painful times of bereavement and occurs when there is least support. There are several reasons for this.

    - The reality that the dead person is never returning is starting to sink in fully. There may be fear of losing the memories and difficulty in visualising the person. Reinforce that this is temporary.
    - The physical coping mechanisms of severe stress have stopped by this time causing physical and emotional exhaustion.
    - Society's expectation is for bereaved people to be back on their feet again after three months. Support from friends has usually worn thin by this time leading to intense loneliness.

2. Grieving patients commonly present with somatic symptoms even several years later. Active grieving may continue for five years or more - particularly with parents.

3. Help plan how to cope with anniversaries, and festivals, such as Christmas and Mother's Day. These usually emphasise the absence of the loved one. Grief is likely to resurge at these times and at times of crisis. Planning these festivals helps to provide some meaningful activity which helps relieve the stress of anticipating the event. Activities which focus on the deceased person need to be mixed with celebrations relevant to the remaining family members. Afterwards there are usually feelings of relief the event is over.

4. Discuss with parents the risks of suicide in their other children. Worry about this is a common issue.

HELPING THE FAMILY WITH GUILT

Help them to be objective.

Bereaved people are so emotionally close to their pain that they find it difficult to be objective. Much of the guilt is imagined and they may use it to punish themselves for allowing the suicide to occur.

Tell them they are not to blame.

Although they may find this paternalistic, you will be able to point to evidence from what they tell you about the history of the suicide.

They could not have been 'super-responsible'.

No-one can be in control of another person's life. The young person who suicided was independent. It was their decision to take their life. It may be that the family can trace a series of decisions the young person made to go along the path they took.

MODELS OF SUICIDE

The sociological model

Stresses overwhelm the young person. These include pressures to perform at school, struggles with relationships and sexual identity, meeting their own expectations of themselves, and traumas such as marital disharmony in families, and sexual or physical abuse.

Personality

Some young people may be more susceptible than others through lack of coping skills or by sensitivity to the woes of the world through their nature. Many young people who suicide are sensitive, caring or perfectionist.

Mental illness

Medical studies have shown up to 95% of people who suicide suffer a mental illness. Depression, schizophrenia, alcohol and other substance abuse and personality disorders are the main causes.

The neurotransmitter model

Recent post mortem studies have demonstrated evidence of long term serotonin depletion in the brain of people who have suicided. This is similar to the depletion of adrenalin and noradrenalin associated with mood disturbances. It is thought serotonin depletion may seriously interrupt the thinking processes and may provide an explanation for suicide. It appears serotonin is low whatever the mental illness suffered beforehand and even in impetuous suicides. It may be that serotonin is depleted through coping with severe stress. This ties in with the sociological model as well as providing a physical disease model. By likening the neurotransmitter model to a physical disease process such as diabetes or cancer, you can present them with a model which carries no blame or stigma, alleviates their guilt and may help to answer the question 'Why did s/he do it?'.

** *This model has been found to be particularly helpful to bereaved people.* **

VARIANTS OF GRIEF

Post traumatic stress disorder

This is a disorder that occurs as the result of exposure to or learning about "an extreme traumatic stress ... that involves actual or threatened death or serious injury or other threat to one's physical integrity" (DSMIV) in which the following symptoms are a constant feature (for a period of more than one month): extreme anxiety with somatic accompaniments, compulsive repetition of the traumatic episode in dreams and while awake, avoidance of associated stimuli and social withdrawal[1].

FOOTNOTE

1. Spragg G *Post traumatic stress disorder.* Medical Journal of Australia 1992; 156:731-733

Chronic grief

Chronic grief is marked by a prolonged, unchanging state indistinguishable from clinical reactive depression in response to the suicide. The griever is withdrawn and socially inhibited, preoccupied with the loved one and in which guilt and self reproach feature largely.[2]

Delayed, absent or inhibited grief

The griever denies or cannot acknowledge the loss and shows no external signs of grieving for several weeks or more. Grief is often triggered by some other event.[2]

CHILDREN, YOUNG PEOPLE AND GRIEF: ASSISTING THE PARENTS

Children and young people need quality parenting following a suicide in the family. Parents have a double burden; attending to the needs of their own grief and those of the children. There are specific issues with which parents request help:

- what to tell the children about the cause of death (see relevant section);
- talking to children about how they feel. Parents may be tempted not to talk with children about how they feel assuming they don't understand. Children may not appear to be grieving when in fact they are hurting very much. Even very young children know when something is desperately wrong in a family and because it may resemble times when they are disciplined, they may feel they were in some way responsible for the suicide. Children's fantasies can be laid to rest and they can feel much more secure when they can confide in a parent. They may need reassurance that no-one else in the family is going to die too;

FOOTNOTE

2. **Middleton W, Moylan A, Raphael R, Martinek N.** *An international perspective on bereavement related concepts.* Australian and New Zealand Journal of Psychiatry 1993; 27: 457-463

- young children may need help in understanding that death is a permanent state;
- how to behave in front of young ones. Information will help, such as 'It's OK to cry in front of the children but also tell them how you feel'. This models good grieving behaviour for the children and encourages them to talk about their feelings. Sharing emotions in this way enables family members give each other mutual support and prevents feelings of isolation;
- anxiety about young people's behaviour. Parents frequently do not recognise that changes in their offspring's behaviour are forms of grieving: feelings may be acted out through play; poor school performance may be caused by pre-occupation with the death; grief may cause angry outbursts and violence; drugs and alcohol may be a form of escapism;
- identifying these behaviours provides opportunity for the adult to discuss issues disturbing the young person.

FOLLOW UP OF THE BEREAVED

When?

- 24 hours
- One week
- One month
- Four months
- One year
- Subsequent anniversaries as appropriate

What?

- grief process
- mental health, especially suicidal thoughts
- practical needs eg child care etc
- general health; especially blood pressure
- lifestyle education
- intercurrent symptoms

How?

A practice death register giving the name of the deceased, cause of death, date of death, and names of practice patients affected by the death may assist follow up. A phone call to the relevant persons is greatly appreciated and long remembered.

GRIEF COUNSELLING

Active Listening

Active listening is the first task of grief counselling. It helps the catharsis, raises self esteem and leads to an understanding of the grief process. It needs to cover three topics:

- the story of the suicide, including the time leading up to it, the suicide itself, the funeral and wake;
- feelings and emotions of the bereaved person;
- person who took their life. Because you are removed from the family you can play an important role in maintaining the significance of the loved one. Bereaved people can feel very hurt that no-one will talk about the dead person and this generally happens because others do not know what to say or fear to 'upset' the bereaved. Consequently family members are prevented from talking about the lost person and yearn for the comfort this might bring. Ask to see a photo.

Narrative Therapy

Narrative approaches are particularly useful in changing attitudes in the grieving process and altering perceptions of self. Lack of self esteem is commonly a major issue following suicide and narrative therapy may help the patient recognise their strengths and coping abilities, which in turn fuels their motivation for grief recovery. This can be important for depressed patients.

Mark Progress

This helps to highlight evidence of the patient's strengths and coping abilities. You can do this by drawing comparisons of progress over a period of time. Also filling in the Grief Map may demonstrate visually the progress the patient has made.

Logotherapy

This is the process of finding meaning from the tragedy. It may be a powerful process in giving hope, and motivating change, particularly attitudes to the grief process and perceptions of self, and raising self esteem.

Meaning can be derived from two sources:

- discovering personal growth through the grieving process. Questions for counselling include 'How have you grown as a person since X's death?'
- in continuing the meaning of the life of the loved one. Questions for counselling include 'What was particularly precious to you about your loved one? How would you like to preserve these memories?'

Homework

Often all we can do in the course of the consultation is sow seeds of thought. By giving patients homework we can encourage those seeds to grow. Examples include asking patients to:

- list their achievements or strengths. This helps to reinforce how well they are coping;
- write a letter to their loved one which can be kept, or buried under the headstone or a rosebush for example. This may help resolve matters of unfinished business;
- consider questions of logotherapy.

REFERENCES

1. **Dunne EJ, McIntosh JL, Dunne-Maxim K,** 1987. *Suicide And Its Aftermath: Understanding And Counselling The Survivors.* New York: Norton. A book for professionals and helpers of the bereaved.

2. **Smolin A, Guinan,** 1993. *Healing After The Suicide Of A Loved One.* Simon & Schuster, New York. Sensitively addresses many issues of suicide bereavement by authors experienced in running groups for the bereaved.

3. **Clark SE, Goldney RD,** 1995. *Grief Reactions And Recovery In A Support Group For People Bereaved By Suicide.* Crisis, 16:27-33.

4. **Clark SE, Jones HE, Quinn K, Goldney RD, Cooling PJ,** 1993. *A Support Group For People Bereaved Through Suicide.* Crisis, 14:161-166.

5. **Cleiren M,** 1993. *Bereavement And Adaption: A Comparative Study of the Aftermath of Death.* Hemisphere Publishing Corporation, London.

6. **van der Wal J,** 1989. *The Aftermath Of Suicide: A Review Of The Empirical Evidence.* Omega, , 20:149-171.

7. **Raphael B,** 1984. *The Anatomy Of Bereavement: A Handbook For The Caring Professions.* Hutchinson, London.

8. **Parkes CM,** 1985. *Bereavement.* British Journal of Psychiatry, 146:11-17.

RESOURCES FOR BEREAVEMENT - PROFESSIONALS

The Doctors' Health Advisory Service

NSW, ACT & NT	02 9437 6552
Queensland	07 3833 4352
South Australia	08 8273 4111

Further Training in Management of Loss and Grief

A **Loss and Grief** subject may be taken on its own or as part of:

The Graduate Diploma in General Practice Psychotherapy
Department of General Practice
University of Adelaide
North Terrace, Adelaide, SA 5000

Tel:	08 8303 3463
Fax:	08 8303 3511

RESOURCES FOR BEREAVEMENT

BOOKS

1. **Clark S,** (1995) *After Suicide: Help For The Bereaved.* Hill of Content Publishing Company Pty Ltd, Melbourne. Suitable as a self help book for the early days of bereavement and subsequently.

2. **Alexander V,** (1991). *Words I Never Thought To Speak.* Lexington Press, New York. Personal journeys of several people following the death of a loved one by suicide.

3. **Wertheimer A.** *A Special Scar. The Experiences Of People Bereaved By Suicide.* Tavistock/Routledge, London & New York. A comprehensive review of suicide bereavement - Suitable for the in-depth reader.

4. **Lukas C & Seiden H.** *Silent Grief: Living In The Wake Of Suicide.* Papermac, London. A guide to survival written by a man who experienced multiple suicides in his family. Co-authored by the psychologist who helped him through.

The following are available from:
Rose Education, PO Box, Camden, NSW 2570.
Tel: (02) 9606 6853 • Fax: (02) 9606 5552

5. **Appleby M.** *Surviving The Pain After Suicide.*

6. **Appleby M & Duncan M.** *Reflections ... For Those Bereaved After Suicide.*

7. **Bolton I.** *My Son, My Son. A Guide To Healing After Suicide.*

VIDEOS

The following are available from:
Foundation Studios, 72 King William Road, North, Adelaide, SA 5006. Tel
Tel: (08) 8204 7339 • Fax: (08) 8204 6699

1. **Suicide: ... The Ultimate Rejection**
   The Bereaved Through Suicide Support Group, SA. Interviews with bereaved people in the early days of bereavement and with the professionals who help them.

2. **Suicide: ... Some Years Down The Track**
   The Bereaved Through Suicide Support Group, SA. Interviews with some of the same people some years later and which describe what helped them through their grief.

SUICIDE BEREAVEMENT SUPPORT GROUPS

SOUTH AUSTRALIA

Bereaved Through Suicide Support Group
PO Box 151
Kent Town SA 5071

Contact:
Diana (08) 8332 2696
Marg (08) 8332 3373

After Suicide Support Group
Woodcroft Community Health Centre
175 Bains Road
Woodcroft SA 5162

Contact:
Elise Lesley-Allen (08) 8325 8100

VICTORIA

"Spring"
Lady of Assumption Church
9 Centre Dandenong Road
Cheltenham Vic 3192

Contact:
Kathleen Crawford (03) 9521 6567
Central Bayside Community Health Service, Hampton Branch

Florence Gibbs (03) 9585 0272
Central Bayside Community Health Service, Mentone Branch

NEW SOUTH WALES

Survivors of Suicide Support Group
Life Line Macarthur
PO Box 217
Camden NSW 2570

Contact: (046) 46 2233

Bereaved by Suicide Support Group
Salvation Army
Cnr Johnson and Archer Streets
PO Box 687
Chatswood NSW 2057

Contact: (02) 9419 8695

DASH
PO Box 114
Bay Village NSW 2261

Contact:
Lionel Reely (043) 32 6738

SHARE
Central Coast Area Health Service
Mandala Clinic Gosford NSW

Contact:
Mark Joyce (043) 20 3170
Susan Syddall (043) 20 3170

SUICIDE BEREAVEMENT SUPPORT GROUPS

QUEENSLAND

Suicide Survivors Support Group
(Cairns)

Contact:
Fran (mobile) 015 966 808

Bereaved by Suicide Support Group
Friendship House
20 Balfort St
Newfarm Qld 4005

Contact: (07) 3358 4988

Survivors of Suicide Support Group
9 Harvey Street
Gladstone Qld 4680

Contact: (079) 78 1843
Shirley Deno (079) 78 1583

WESTERN AUSTRALIA

Survivors of Suicide Support Group
Samaritan House
60 Bagot Road
Subiaco Perth WA 6008

Contact: (09) 382 3811
Lin Young (09) 382 3720

TASMANIA

Dorset Support Group
Scotsdale TAS
RSD 232 Rungaroona 7263

Contact:
Dot Ranson (ph/fax) (03) 6354 2485

INSTRUCTIONS FOR WORKSHOP PROVIDERS TO GENERAL PRACTITIONERS

"Keep Yourself Alive" has been granted 3 CME points per hour, totaling 21 points for the entire program in the 1996-1998 triennium of the Royal Australian College of General Practitioners (RACGP) Quality Assurance and Continuing Education (QA&CE) Program. These points are not guaranteed and are subject to review by the RACGP.

For the above points to be awarded to participants the following conditions must be met:

1. **Workshop Provider must register** with QA&CE Program Unit (SA), see details below. Please use the Registration form *(Appendix 2.1)* provided. As a registered provider, you will be given a **Provider ID Number** and **Activity Code Number** for "Keep Yourself Alive". Without these numbers, the GP's will not be granted points and you will not be able to issue appropriate certificates of attendance. As a registered provider, you will also be entitled to additional "Keep Yourself Alive" Resource packs, free of charge.

2. You must send the **"GP Registration Form"** *(Appendix 2.3)* to participants **prior to the workshop**. Insert the Provider ID Number on these registration forms. The registration forms must be returned to you for results of the returned registration forms will ensure that you, as the education provider, have a clear understanding of the educational needs of your audience.

   Once you have analysed the results of the **registration forms** for your own purposes forward these to the QA&CE Program Unit (SA) at the address below.

3. At the end of the workshop have the GP's complete the **"GP Evaluation Form"** included in this manual *(Appendix 2.4)*. You will need to forward **ALL** of these evaluations to the QA&CE Program Unit (SA) at the address below. **At this stage only 2 points per hour will be issued by the QA&CE Program Unit (a maximum of 14 points per workshop).**

   NB: *If the QA&CE Program Unit does not receive a completed evaluation form for a particular GP, we will not be able to allocate any points to that individual at all!*

4. **Inform the GP's that the QA&CE Program Unit (SA), will be forwarding to them the resource package as well as three case scenarios to complete.** These will arrive 6-12 weeks after the workshop. The GP's will need to complete and return these to the QA&CE Program Unit (SA) at the address below. When these have been received a further 7 CME points will be automatically allocated to their CME point statements.

5. You must **issue each GP with a certificate of attendance** that states: the date and times of the workshop and the Activity Code Number. An example is included in this manual. *(Appendix 2.2)*.

Please direct any correspondence and/or questions to:

RACGP, QA&CE Program Unit (SA)
"Keep Yourself Alive"
15 Gover Street
NORTH ADELAIDE SA 5006

Tel: (08) 8267 1888
Fax: (08) 8361 8667

INSTRUCTIONS FOR WORKSHOP PROVIDERS TO OTHER HEALTH PROFESSIONALS

1. **Workshop Provider must register** with Southern CAMHS, see details below. Please use the Registration form (Appendix 2.1) provided. As a registered provider, you will be given a **Provider ID Number** and you will be entitled to additional "Keep Yourself Alive" resource packs, free of charge.

2. You must send the **"Other Health Professionals Registration Form"** *(Appendix 2.6)* to participants **prior to the workshop**. Insert the Provider ID Number on these registration forms. The results of the returned registration forms will ensure that you, as the education provider, have a clear understanding of the educational needs of your audience.

   Once you have analysed the results of the **registration forms** for your own purposes, forward these to Southern CAMHS at the address below.

3. At the end of the workshop have the health professionals complete the **"Other Health Professionals Evaluation Form"** included in this manual (Appendix 2.7). You will need to forward ALL of these evaluations to Southern CAMHS, at the address below.

Please direct any correspondence and/or questions to:

Southern CAMHS
"Keep Yourself Alive"
Flinders Medical Centre
BEDFORD PARK SA 5042

Tel: (08) 8204 4212
Fax: (08) 8204 5465

INSTRUCTIONS FOR GENERAL PRACTITIONERS UNDERTAKING "KEEP YOURSELF ALIVE" AS A DISTANCE LEARNING PROGRAM

"Keep Yourself Alive" has been granted 3 CME points per hour, totaling 21 points for the entire program in the 1996-1998 triennium of the Royal Australian College of General Practitioners (RACGP) Quality Assurance and Continuing Education (QA&CE) Program. These points are not guaranteed and are subject to review by the RACGP.

For the above points to be awarded to participants the following conditions must be met:

1. **You must register using the GP Registration Form** in this manual *(see Appendix 2.3)*. Post the completed form to the QA&CE Program Unit (SA) at the address given below. You will then be provided with a GP ID number and the Activity Code Number for "Keep Yourself Alive". Without these numbers you will not be able to complete the program and be granted points.

2. **View the video tapes and listen to the audio tapes.** (Use the manual as a reference guide for additional information.)

3. After you have finished watching and listening to the material **complete the GP Evaluation Form** *(Appendix 2.4)* in this manual and send it to QA&CE Program Unit (SA) at the address given below.

   NB: If the QA&CE Program Unit does not receive a completed evaluation form, we will not be able to allocate any points at all!

4. Six to 12 weeks after the QA&CE Unit has received your GP Evaluation Form, **we will send you 3 Case Scenarios to complete** *(an example is included in Appendix 2.5)*. Please insert your GP ID number and your QA number on these forms. Return the completed forms to the QA&CE Program Unit (SA) at the address given below.

5. **The QA&CE Program Unit will score these and return these to you with an "ideal answer sheet".** Your score compared to other GP's and the ideal answers will be provided for your information.

6. Finally, you will have received with your answer sheets a **GP Feedback Form.** This form will ask you to analyse your performance in the program and seek your advice and feedback. Your comments will be used as a basis for further refinement of the program and in the development of other distance learning packs.

7. When this GP Feedback Form has been received, the QA&CE Program Unit will **automatically allocate 21 CME points** to your point tally and issue you with a certificate of completion.

Please direct any correspondence and/or questions to:

RACGP, QA&CE Program Unit (SA)
"Keep Yourself Alive"
15 Gover Street
NORTH ADELAIDE SA 5006

Tel: (08) 8267 1888
Fax: (08) 8361 8667

APPENDICES – APPENDIX 1D

PRACTICE ASSESSMENT OPTION - "YOUNG PEOPLE IN YOUR PRACTICE"

"Young People in Your Practice" has been awarded 25 Practice Assessment Points in the 1996-8 triennium of the Royal Australian College of General Practitioners (RACGP) Quality Assurance and Continuing Education Program. (Points are subject to review and are not guaranteed by the RACGP). There is **NO CHARGE** for taking part in this PA option.

OVERVIEW

This PA Activity is designed to complement the youth suicide prevention project "Keep Yourself Alive". It becomes a component of the approach to reduce youth suicide by focusing more broadly on the health of young people in general practice. It aims to reinforce the learning that is undertaken in the seminars and workshops. It comprises three components, a questionnaire to young people about their emotional and social health and the responsiveness of the practice and general practitioner to their needs. The general practitioner is required to make assessments of young people and their overall well being. Finally, the general practitioner completes a "Youth Access Checklist" for their practice. The results are analysed and returned to the GP. The GP is then required to review their clinical practice and practice management procedures to see where changes can be made to better meet the needs of young people in their practice. The complete process is then repeated 6 months later to see if the changes have been effective.

HOW TO ENROL IN THIS OPTION?

To enrol in the Practice Assessment Option contact:

RACGP, Quality Assurance Unit (SA)
15 Gover Street
NORTH ADELAIDE SA 5006

Tel: (08) 8267 1888
Fax: (08) 8361 8667

PROVIDER REGISTRATION FORM

Workshop Provider Name:

_____

Type of Organisation:
(eg: Division of General Practice, Community Health Organisation, Private Individual)

_____

Provider Address:

_____

_____ Post Code: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____

E-mail: _____

Proposed Location of Workshop(s)	**Proposed Date(s) of Workshop(s):**
1.	1.
2.	2.

Name(s) of Presenter(s)	**Profession(s) of Presenter(s)**
1.	1.
2.	2.
3.	3.
4.	4.

SAMPLE OF GP ATTENDANCE CERTIFICATE

This is to certify that:

_____

GP'S FULL NAME

attended the

_____

"Keep Yourself Alive"
97-Q9-0113

held by

_____

PROVIDER NAME

on

_____

DATE/S

CME Points will be allocated on completion of all requirements by the Royal Australian College of General Practitioners QA&CE Program (SA).
CME point allocation is not guaranteed and is subject to review by the RACGP.

KEEP YOURSELF *ALIVE*

Name	Date of Birth:
QA Number:	
Practice Address:	
	Postcode:
Phone:	FAX:

Date of workshop:	Presenters:
Venue:	Sponsoring Organisation:

Please circle where appropriate

1. Gender: Female Male
2. Years in Practice: <5 5-9 10-14 15-19 >20
3. Number of GP's in your practice (including yourself): solo 2 3-5 5-9 >10
4. Part time _____ hours/week or full time
5. Average Number of Patients seen by you per week: <25 26-50 50-74 75-100 101-149 >150
6. Post Graduate Qualifications: FRACGP CSCT Other _____
7. How many young people do you feel have presented to you in the last 12 months as being seriously suicidal? _____
8. How many attempted suicides of any age have you had in your practice in the last 5 years? _____
9. How many completed suicides of any age have you had in the last 5 years? _____
10. How many people in your practice have been affected by the completed suicide of a friend or relative in the last 5 years? _____

11a. How much time would you give in the **initial** consultation for a young patient who is seriously suicidal?
<15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes

11b. How would you define this **initial** consultation for Medicare purposes?
Level A Level B Level C Level D
or Item Number 160-164 *(prolonged professional attendance for a patient in imminent danger of death)*

12a. How much time would you allow in **a follow up** consultation for a young patient who has been suicidal?
<15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes

12b. How would you define the follow up consultation for Medicare purposes?
Level A Level B Level C Level D Other Item Number
eg: 170, 171 *(GP Group therapy of 2-3 persons)*

13. How much time would you spend arranging for follow up or referral of a seriously suicidal young person?
<15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes

14a. How would you define the follow up or referral arrangement (in question 13) for Medicare purposes?
Level A Level B Level C Level D Not an item Number (no charge)

14b. How do you normally follow up a family bereaved through suicide?

No contact	Phone call				
Consultation:	Level A	Level B	Level C	Level D	Item Number 170-172
Home Visits:	Level A	Level B	Level C	Level D	Item Number 170-172

15. Please indicate how important the following issues are as antecedents of adolescent suicide.

	Not at all important		⇨		*Extremely Important*
Family pressures	1	2	3	4	5
Relationships	1	2	3	4	5
Academic pressures	1	2	3	4	5
Work issues	1	2	3	4	5
Unemployment	1	2	3	4	5

16. Indicate the order of the following factors from 1 (= least important) to 10 (= most important) as contributing factors to suicidal behaviours or indicators of suicidal intent.

- ☐ Alcohol use
- ☐ Physical or sexual abuse
- ☐ Previous attempt
- ☐ Knowledge of someone who has suicided
- ☐ Social isolation
- ☐ Unsupportive family
- ☐ Recent bereavement or loss
- ☐ Plans for suicide
- ☐ Self inflicted injury
- ☐ Lethal means available

PTO

17. Please indicate on the following scales what percentages of young people you believe have: -

Ever thought of suicide as a way to solve their problems.

0% _____ 100%

Made suicidal threats:

0% _____ 100%

Made suicidal plans:

0% _____ 100%

Incurred deliberate self harm or mutilation:

0% _____ 100%

18. Which of the following counselling techniques or methods do you use already? (Tick)

☐ Crisis Intervention ☐ Narrative Therapy ☐ Cognitive Behaviour Therapy

☐ Brief Intervention ☐ Logotherapy ☐ Classical Psychotherapy

☐ Psychodrama (Action Methods) ☐ Other _____

19. Please circle whether you agree or disagree with the following statements

	Strongly Disagree		⇨		*Strongly Agree*
a) Where suicide is a strong possibility, the GP should warn the family of the possibility.	1	2	3	4	5
b) I feel ill equipped to deal with the anger families may have towards a GP if a young person dies.	1	2	3	4	5
c) As a GP I find it difficult to deal with the family's emotions when a young person dies.	1	2	3	4	5
d) I feel extremely stressed when dealing with a seriously suicidal young person.	1	2	3	4	5
e) I feel ill-equipped to assist the families after a suicide.	1	2	3	4	5

20. How important would the following be in assisting you deal with adequately with a suicidal young person?

	Not Important		⇨		*Extremely Important*
a) Additional time for the consultation and follow up.	1	2	3	4	5
b) Additional remuneration for dealing with a seriously suicidal person.	1	2	3	4	5
c) Additional training.	1	2	3	4	5
d) Additional local resources and mental health programs for referral.	1	2	3	4	5
e) Shared Care with local mental health professionals or psychiatrists.	1	2	3	4	5

Thank You!

Dr Name	Date of Birth:
QA Number:	**GP ID Number (distance learning only):**
Date Completed:	Location of Workshop:
Your Practice Postcode	
Presenters (for workshops only):	
Organisation providing the Workshop:	
Workshop Provider ID Number:	

Section One - RECOGNISING THE SIGNS

Please circle where appropriate

1. Please indicate how important the following issues are as antecedents of adolescent suicide.

	Not at all important		⇨		*Extremely Important*
Family pressures	1	2	3	4	5
Relationships	1	2	3	4	5
Academic pressures	1	2	3	4	5
Work issues	1	2	3	4	5
Unemployment	1	2	3	4	5

2. Indicate the order of the following factors from 1 (= least important) to 10 (= most important) as contributing factors to suicidal behaviours or indicators of suicidal intent.

- ☐ Alcohol use
- ☐ Physical or sexual abuse
- ☐ Previous attempt
- ☐ Knowledge of someone who has suicided
- ☐ Social isolation
- ☐ Unsupportive family
- ☐ Recent bereavement or loss
- ☐ Plans for suicide
- ☐ Self inflicted injury
- ☐ Lethal means available

3. Please indicate on the following scales what percentages of young people you believe have: -

Ever thought of suicide as a way to solve their problems.

0% _____ 100%

Made suicidal threats:

0% _____ 100%

Made suicidal plans:

0% _____ 100%

Incurred deliberate self harm or mutilation:

0% _____ 100%

Section Two - CRISIS INTERVENTION

4. There are six key steps to crisis intervention - in the boxes provided place these in order of 1 - 6.

- ☐ Obtain commitment
- ☐ Provide support
- ☐ Examine alternatives
- ☐ Define the problem
- ☐ Ensure safety
- ☐ Make plans

5. The triage approach allows exploration of suicidal risk - ✓ which of the following is NOT part of this assessment process: (tick only one)

- ☐ a) assessment of the emotional state
- ☐ b) assessment of suicidal risk
- ☐ c) assessment of family supports

6. ✓ which of the following elements a "no suicide contract" should contain: (as many as apply)

- ☐ a) the young person's name and signature
- ☐ b) the doctor's name and signature
- ☐ c) where and when it was made
- ☐ d) all of the above

Section Three - COUNSELLING APPROACHES

7. Narrative therapy involves separating the person from the problem. ☐ True ☐ False
8. The Narrative approach involves finding a way to reframe the patient's problem into a positive attribute of their coping mechanisms. ☐ True ☐ False
9. Cognitive Behaviour Therapy involves finding an exception to the problem ☐ True ☐ False

PTO

Section Three - COUNSELLING APPROACHES cont.

10. Brief Intervention Approaches typically last 2-3 weeks ❑ True ❑ False

11. Scaling questions are useful to assess the severity of problems. ❑ True ❑ False

12. Using a narrative approach, frame a reflective response to the following statement -
"I hate them! They just won't leave me alone - it's my life I can do what I want with it!"

_____

_____

13. Using a Cognitive Behaviour approach frame a response to the following statement -
"There's nothing left for me anymore - my life is over anyway"

_____

_____

14. Propose a course of action to this scenario using a Brief Intervention solution focussed approach:
A young male aged 19 comments that "the quickest way to do it would be to hit a tree at 140 clicks"

_____

_____

Section Four - POSTVENTION - AFTER SUICIDE

15. After the suicide of a young person the GP should wait 24 hours before contacting the family to allow them privacy in their time of loss. ❑ True ❑ False

16. After the suicide of a young person the GP should wait 24 hours before contacting the family because the GP needs to sort out their own feelings before making any contact. ❑ True ❑ False

17. Grieving a suicide follows a set course of stages and phases. ❑ True ❑ False

18. Anger is usually the most difficult emotion for the bereaved following a suicide. ❑ True ❑ False

19. Three to four months after a suicide can be the most difficult time emotionally in the grieving process. ❑ True ❑ False

20. Children should not view the body of the young person because of the impact that it could have on their own long term emotional health. ❑ True ❑ False

21. When a young person takes their life:
a) the bereavement reaction is usually more severe for the parents than other members of the family. ❑ True ❑ False
b) the grief may be more complicated than following a death from natural causes. ❑ True ❑ False
c) the other children in the family should be told details of the exact method of suicide. ❑ True ❑ False

22. In assisting the family deal with the aftermath of a suicide:
a) they should be advised to have a private funeral. ❑ True ❑ False
b) they should avoid hypnotics and sedatives before the funeral. ❑ True ❑ False
c) they should be prescribed anti-depressants if the mood stays emotionally low without any mood swings. ❑ True ❑ False

23. Please circle whether you agree or disagree with the following statements.

	Strongly Disagree		⇨		*Strongly Agree*
a) Where suicide is a strong possibility, the GP should warn the family of that possibility.	1	2	3	4	5
b) I feel ill equipped to deal with the anger families may have towards a GP if a young person dies.	1	2	3	4	5
c) As a GP I find it difficult to deal with the family's emotions when a young person dies.	1	2	3	4	5
d) I feel ill-equipped to assist the families after a suicide.	1	2	3	4	5

24. How important would the following be in assisting you deal adequately with a suicidal young person?

	Not at all important		⇨		*Extremely Important*
a) Additional time for the consultation and follow up.	1	2	3	4	5
b) Additional remuneration for dealing with a seriously suicidal person.	1	2	3	4	5
c) Additional training	1	2	3	4	5
d) Additional local resources and mental health programs for referral.	1	2	3	4	5
e) Shared Care with local mental health professionals or psychiatrists.	1	2	3	4	5

Thank You!

CASE SCENARIO EXAMPLE

"Just a sore throat?"

Rebecca, a previously well girl aged 15 years, presents with a few days history of a sore throat characterised by generalised tiredness, tonsillar exudate, erythema of the pharynx, cervical lymphadenopathy and fever. You also notice on examination she looks a little pale and thin. Your provisional diagnosis is acute tonsillitis.

Which one of the following is true with regard to tonsillitis?
Circle as many as apply.

1. Bacterial infections are distinguishable from those of viral aetiology, by the presence of exudate, local adenopathy and absence of coryza.
2. Investigations such as throat swab and anti-streptolysin titre (ASOT) are useful in diagnosis and management.

more options available...

You treat Rebecca with penicillin 250 mg q.d.s orally for 10 days. However, she returns after two weeks, this time complaining of a sore throat as well as lethargy, dizziness, frontal headaches and difficulty sleeping. Examination on this consultation is unremarkable except you notice again that she is slightly pallid and thin. No abnormality is detected on examination of head and neck; her chest is clear; she has a lax abdomen with no palpable masses; central nervous system is normal and urine full ward test shows no albumin or sugar.

You decide to question Rebecca more specifically about her home life. She explains that over the last two weeks she has been staying at a motel with her father on an access visit. Her parents separated some six months ago and her father lives 500 km from the family. She tells you that during those two weeks, her father spent a lot of time denigrating her mother which has upset and confused Rebecca. You now feel Rebecca has acute depression related to family dysfunction.

How to engage the adolescent-strategies for gaining trust when taking a history [adapted from AFP, Nov 1995; p2042-Table 2]

- Attempt to talk to the patient alone, away from family members.
- Acknowledge that it may have been difficult for the adolescent to get to the doctor.
- Be reassuring and explain that any embarrassment is normal.

... more information included...

Having provisionally diagnosed her as suffering from a depressive illness related to the situational crisis, what are important factors to consider in assessing Rebecca's suicide risk? Circle as many as apply.

1. Evidence of substance use disorder
2. Details of suicidal ideation and past suicide attempts

more options available...

This case continues...

Name _____ Date of Birth: _____

Profession: _____ Workshop Provider ID Number: _____

Your Work Address: _____

Postcode: _____

Phone: _____ FAX: _____

Please circle where appropriate

1. Gender: Female Male
2. Type of agency or organisation you work for: _____
3. Part time _____ hours/week or full time
4. Average Number of Clients seen by you per week: <25 26-50 50-74 75-100 101-149 >150
5. Qualifications: _____
6. How many young people have you dealt with in the last 12 months who were seriously suicidal? _____
7. How many attempted suicides, who were seriously suicidal, have you dealt with in the last 12 months? _____
8. How many clients suicided in the last 5 years? _____
9. How many people do you professionally deal with who have been affected by the suicide of a friend or relative? _____
10. How much time would you give in the **initial** session for a young person who is seriously suicidal?
    <15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes
11. How much time would you allow in **a follow up** session for a young person who has been suicidal?
    <15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes
12. How much time would you spend arranging for **follow up** or **referral** of a seriously suicidal young person?
    <15 minutes 16-30 minutes 31-45 minutes 46-60 minutes >60 minutes
13. Please indicate how important the following issues are as antecedents of adolescent suicide.

	Not at all important		⇨		*Extremely Important*
Family pressures	1	2	3	4	5
Relationships	1	2	3	4	5
Academic pressures	1	2	3	4	5
Work issues	1	2	3	4	5
Unemployment	1	2	3	4	5

14. Indicate the order of the following factors from 1 (= least important) to 10 (= most important) as contributing factors to suicidal behaviours or indicators of suicidal intent.

- ☐ Alcohol use
- ☐ Physical or sexual abuse
- ☐ Previous attempt
- ☐ Knowledge of someone who has suicided
- ☐ Social isolation
- ☐ Unsupportive family
- ☐ Recent bereavement or loss
- ☐ Plans for suicide
- ☐ Self inflicted injury
- ☐ Lethal means available

15. Please indicate on the following scales what percentages of young people you believe have: -

Ever thought of suicide as a way to solve their problems.
0% _____ 100%

Made suicidal threats:
0% _____ 100%

Made suicidal plans:
0% _____ 100%

Incurred deliberate self harm or mutilation:
0% _____ 100%

16. Which of the following counselling techniques or methods do you use already? (Tick)

- ☐ Crisis Intervention
- ☐ Brief Intervention
- ☐ Psychodrama (Action Methods)
- ☐ Narrative Therapy
- ☐ Logotherapy
- ☐ None
- ☐ Cognitive Behaviour Therapy
- ☐ Classical Psychotherapy

17. Please circle whether you agree or disagree with the following statements

	Strongly Disagree		⇨		*Strongly Agree*
a) I feel ill equipped to deal with the anger families may have towards a Health Professional if a young person dies.	1	2	3	4	5
b) I find it difficult to deal with the family's emotions when a young person dies.	1	2	3	4	5
d) I feel extremely stressed when dealing with a seriously suicidal young person.	1	2	3	4	5
e) I feel ill-equipped to assist the families after a suicide.	1	2	3	4	5

Thank You!

Name	Date of Birth:
Profession:	
Date Completed:	Location of Workshop:
Your Work Postcode	
Presenters (for workshops only):	
Organisation providing the Workshop:	
Workshop Provider ID Number:	

Section One - RECOGNISING THE SIGNS

Please circle where appropriate

1. Please indicate how important the following issues are as antecedents of adolescent suicide.

	Not at all important		⇨		*Extremely Important*
Family pressures	1	2	3	4	5
Relationships	1	2	3	4	5
Academic pressures	1	2	3	4	5
Work issues	1	2	3	4	5
Unemployment	1	2	3	4	5

2. Indicate the order of the following factors from 1 (= least important) to 10 (= most important) as contributing factors to suicidal behaviours or indicators of suicidal intent.

- ☐ Alcohol use
- ☐ Physical or sexual abuse
- ☐ Previous attempt
- ☐ Knowledge of someone who has suicided
- ☐ Social isolation
- ☐ Unsupportive family
- ☐ Recent bereavement or loss
- ☐ Plans for suicide
- ☐ Self inflicted injury
- ☐ Lethal means available

3. Please indicate on the following scales what percentages of young people you believe have: -

Ever thought of suicide as a way to solve their problems.

0% _____ 100%

Made suicidal threats:

0% _____ 100%

Made suicidal plans:

0% _____ 100%

Incurred deliberate self harm or mutilation:

0% _____ 100%

Section Two - CRISIS INTERVENTION

4. There are six key steps to crisis intervention - in the boxes provided place these in order of 1 - 6.

- ☐ Obtain commitment
- ☐ Provide support
- ☐ Examine alternatives
- ☐ Define the problem
- ☐ Ensure safety
- ☐ Make plans

5. The triage approach allows exploration of suicidal risk - ✓ which of the following is NOT part of this assessment process: (tick only one)

- ☐ a) assessment of the emotional state
- ☐ b) assessment of suicidal risk
- ☐ c) assessment of family supports

6. ✓ which of the following elements should a "no suicide contract" contain: (as many as apply)

- ☐ a) the young person's name and signature
- ☐ b) the doctor's/counsellor's name and signature
- ☐ c) where and when it was made
- ☐ d) all of the above

Section Three - COUNSELLING APPROACHES

7. Narrative therapy involves separating the person from the problem. ☐ True ☐ False
8. The Narrative approach involves finding a way to reframe the patient's problem into a positive attribute of their coping mechanisms. ☐ True ☐ False
9. Cognitive Behaviour Therapy involves finding an exception to the problem ☐ True ☐ False

PTO

Section Three - COUNSELLING APPROACHES cont.

10. Brief Intervention Approaches typically last 2-3 weeks ❑ True ❑ False

11. Scaling questions are useful to assess the severity of problems. ❑ True ❑ False

12. Using a narrative approach, frame a reflective response to the following statement -
"I hate them! They just won't leave me alone - it's my life I can do what I want with it!"

_____

_____

13. Using a Cognitive Behaviour approach frame a response to the following statement -
"There's nothing left for me anymore - my life is over anyway"

_____

_____

14. Propose a course of action to this scenario using a Brief Intervention approach (as in Brief Family Therapy):
A young male aged 19 comments that "the quickest way to do it would be to hit a tree at 140 clicks"

_____

_____

Section Four - POSTVENTION - AFTER SUICIDE

15. After the suicide of a young person the Health Professional (HP) should wait 24 hours before contacting the family to allow them privacy in their time of loss. ❑ True ❑ False

16. After the suicide of a young person the HP should wait 24 hours before contacting the family because the HP needs to sort out their own feelings before making any contact. ❑ True ❑ False

17. Grieving a suicide follows a set course of stages and phases. ❑ True ❑ False

18. Anger is usually the most difficult emotion for the bereaved following a suicide. ❑ True ❑ False

19. Three to four months after a suicide can be the most difficult time emotionally in the grieving process. ❑ True ❑ False

20. Children should not view the body of the young person because of the impact that it could have on their own long term emotional health. ❑ True ❑ False

21. When a young person takes their life:
a) the bereavement reaction is usually more severe for the parents than other members of the family. ❑ True ❑ False
b) the grief may be more complicated than following a death from natural causes. ❑ True ❑ False
c) the other children in the family should be told details of the exact method of suicide. ❑ True ❑ False

22. In assisting the family deal with the aftermath of a suicide:
a) they should be advised to have a private funeral. ❑ True ❑ False
b) they should avoid hypnotics and sedatives before the funeral. ❑ True ❑ False
c) they should be prescribed anti-depressants if the mood stays emotionally low without any mood swings. ❑ True ❑ False

23. Please circle whether you agree or disagree with the following statements.

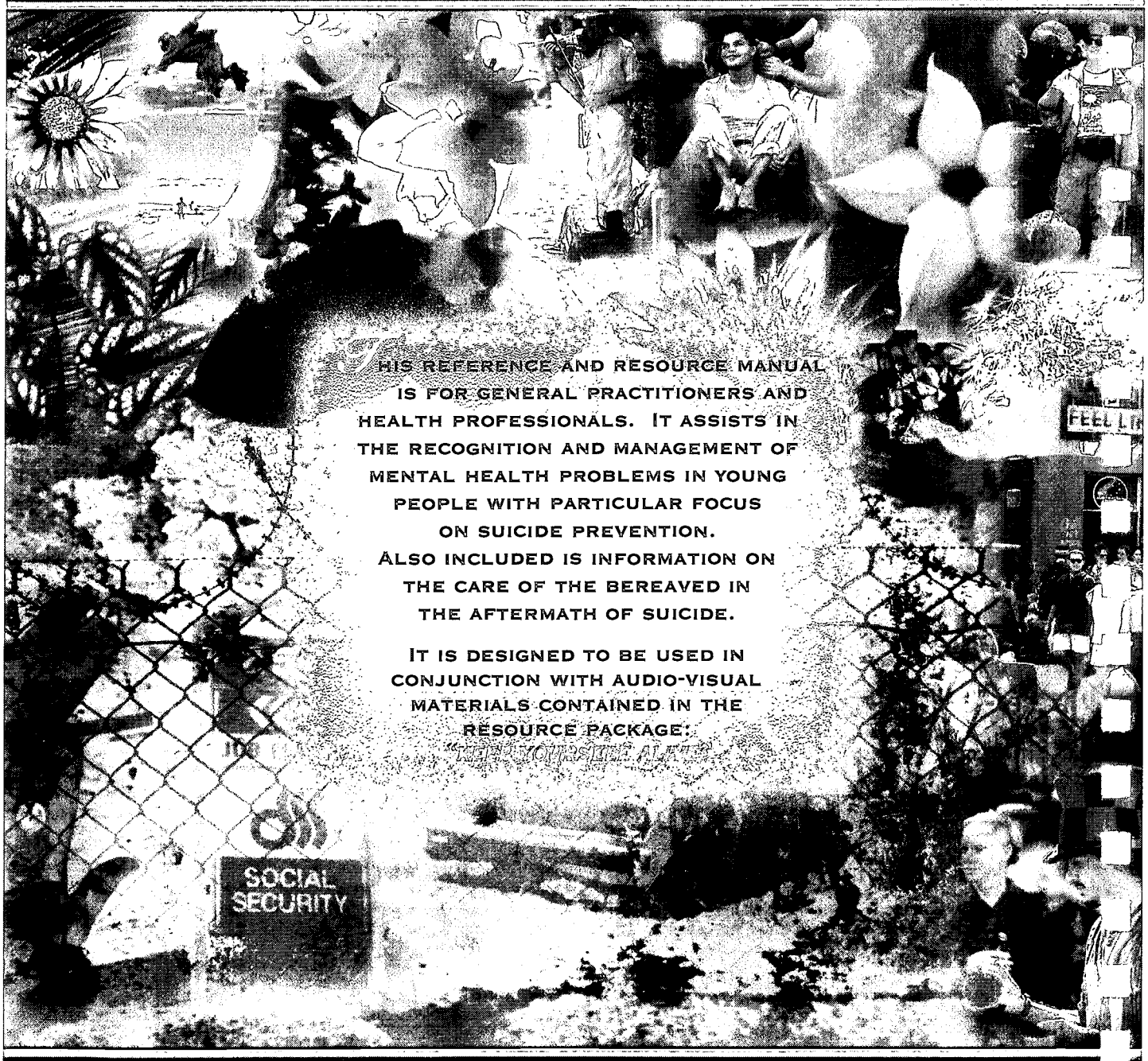
	Strongly Disagree		⇨		*Strongly Agree*
a) I feel ill equipped to deal with the anger families may have if a young person dies.	1	2	3	4	5
b) I find it difficult to deal with the family's emotions when a young person dies.	1	2	3	4	5
c) I feel ill-equipped to assist the families after a suicide.	1	2	3	4	5

Thank You!

NOTES

KEY TOPICS

• RECOGNISING THE SIGNS • CRISIS INTERVENTION •
• THERAPEUTIC APPROACHES • AFTER SUICIDE •



THIS REFERENCE AND RESOURCE MANUAL IS FOR GENERAL PRACTITIONERS AND HEALTH PROFESSIONALS. IT ASSISTS IN THE RECOGNITION AND MANAGEMENT OF MENTAL HEALTH PROBLEMS IN YOUNG PEOPLE WITH PARTICULAR FOCUS ON SUICIDE PREVENTION. ALSO INCLUDED IS INFORMATION ON THE CARE OF THE BEREAVED IN THE AFTERMATH OF SUICIDE.

IT IS DESIGNED TO BE USED IN CONJUNCTION WITH AUDIO-VISUAL MATERIALS CONTAINED IN THE RESOURCE PACKAGE:
"REACH OUT AND TOUCH"

FUNDED UNDER THE AUSTRALIAN COMMONWEALTH GOVERNMENT'S
"HERE FOR LIFE"

Child and Adolescent Mental Health Service

AUSTRALIA

SUV 531

113

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Education Resources Information Center (ERIC)

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION

Title: Keep Yourself Alive: Prevention of Suicide in Young People, A manual for Health Professionals

Author(s): Dr Graham Martin, Dr Sheila Clark, Dr Paul Beckinsale, Ms Kathleen Stacey, Mr Clive Skene

Corporate Source:	Publication Date:
Southern Child & Adolescent Mental Health Service Flinders Medical Centre BEDFORD PARK, SOUTH AUSTRALIA, 5042	1997, ISBN 0 646 32424 1

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Services (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following three options and sign at the bottom of the page.

The sample sticker shown below will be affixed to all Level 1 documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

SAMPLE

TO THE EDUCATION RESOURCES INFORMATION CENTER (ERIC)
1.

Level 1 ↕

☑

Check here for Level 1 release, permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g. electronic) and paper copy

The sample sticker shown below will be affixed to all Level 2A documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY HAS BEEN GRANTED BY

SAMPLE

TO THE EDUCATION RESOURCES INFORMATION CENTER (ERIC
2A

Level 2A ↕

❑

Check here for Level 2A release, permitting reproduction and dissemination in ;microfiche and in electronic media for ERIC archival collection subscribers only

The sample sticker shown below will be affixed to all Level 2B documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

SAMPLE

TO THE EDUCATION RESOURCES INFORMATION CENTER (ERIC
2B

Level 2B ↕

❑

Check here for Level 2B release, permitting reproduction and dissemination in microfiche only

Documents will be processed as indicated provided reproduction quality permits.
If permission to reproduce is granted but no box is checked, documents will be processed at Level 1.

I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries

Sign here → please

Signature:	Printed Name/Position/Title: Assoc Professor Graham Martin Executive Director	
Organisation/Address: Southern Child & Adolescent Mental Health Service, Flinders Medical Centre, BEDFORD PARK, SOUTH AUSTRALIA, 5042	Telephone: 08 8204 5412	Fax: 08 8204 5465
	E-Mail Address: graham.martin@flinders.edu.au	Date: 16.2.99

III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, or, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS).

Publisher/Distributor:
Address:
Price:

IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant this reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

Name:
Address:

V. WHERE TO SEND THIS FORM:

Send this form to the following ERIC Clearinghouse:

ERIC Clearinghouse on Urban Education
Box 40, Teachers College
Columbia University
NEW YORK, NY 10027

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to: